Rhode Island

UNIFORM APPLICATION
FY 2007

SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT

OMB - Approved 08/26/2004 - Expires 08/31/2007

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Center for Substance Abuse Treatment
Division of State and Community Assistance

Introduction:

The SAPT Block Grant application format provides the means for States to comply with the reporting provisions of the Public Health Service Act (42 USC 300x-21-64), as implemented by the Interim Final Rule and the Tobacco Regulation for the SAPT Block Grant (45 CFR Part 96, parts XI and IV, respectively).

Public reporting burden for this collection of information is estimated to average 563 hours per response for sections I-III, 50 hours per response for Section IV-A and 42 hours per response for Section IV-B, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to SAMHSA Reports Clearance Officer; Paperwork Reduction Project (0930-0080); Room 16-105, Parklawn Building; 5600 Fishers Lane, Rockville, MD 20857.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0930-0080.

Form 1

State: Rhode Island
DUNS Number: 883943495

Uniform Application for FY 2007 Substance Abuse Prevention and Treatment Block Grant

I. STATE AGENCY TO BE THE GRANTEE FOR THE BLOCK GRANT

Agency Name: Department of Mental Health, Retardation and Hospitals

Organizational Unit: Division of Behavioral Health Care

Mailing Address: 14 Harrington Road Barry Hall

City: Cranston Zip: 02920

II. CONTACT PERSON FOR THE GRANTEE FOR THE BLOCK GRANT

Name: Craig Stenning

Agency Name: Department of Mental Health, Retardation and Hospitals

Mailing Address: 14 Harrington Road Barry Hall

City: Cranston Zip Code: 02920

Telephone: 401-462-2338 FAX: 401-462-6636

E-MAIL: cstenning@mhrh.ri.gov

III. STATE EXPENDITURE PERIOD

From: 7/1/2005 To: 6/30/2006

IV. DATE SUBMITTED

Date: 9/28/2006 ☒ Original ☐ Revision

V. CONTACT PERSON RESPONSIBLE FOR APPLICATION SUBMISSION

Name: Kim Katrophilio-Harris Telephone: 401-462-0454

E-MAIL: kharris@mhrh.ri.gov FAX: 401-462-0339

Form 2 (Table of Contents)

State:
Rhode Island

UNIFORM APPLICATION FOR FY 2007 SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT
Funding Agreements/Certifications
as Required by the Public Health Service (PHS) Act

The PHS Act, as amended, requires the chief executive officer (or an authorized designee) of the applicant organization to certify that the State will comply with the following specific citations as summarized and set forth below, and with any regulations or guidelines issued in conjunction with this Subpart except as exempt by statute.

We will accept a signature on this form as certification of agreement to comply with the cited provisions of the PHS Act. If signed by a designee, a copy of the designation must be attached.

I. Formula Grants to States, Section 1921

Grant funds will be expended "only for the purpose of planning, carrying out, and evaluating activities to prevent and treat substance abuse and for related activities" as authorized.

II. Certain Allocations, Section 1922

- **Allocations Regarding Primary Prevention Programs, Section 1922(a)**
- **Allocations Regarding Women, Section 1922(b)**

III. Intravenous Drug Abuse, Section 1923

- **Capacity of Treatment Programs, Section 1923(a)**
- **Outreach Regarding Intravenous Substance Abuse, Section 1923(b)**

IV. Requirements Regarding Tuberculosis and Human Immunodeficiency Virus, Section 1924

V. Group Homes for Recovering Substance Abusers, Section 1925
Optional beginning FY 2001 and subsequent fiscal years. Territories as described in Section 1925(c) are exempt.

The State "has established, and is providing for the ongoing operation of a revolving fund" in accordance with Section 1925 of the PHS Act, as amended. This requirement is now optional.

VI. State Law Regarding Sale of Tobacco Products to Individuals Under Age of 18, Section 1926:

- **The State has a law in effect making it illegal to sell or distribute tobacco products to minors as provided in Section 1926 (a)(1).**
- **The State will enforce such law in a manner that can reasonably be expected to reduce the extent to which tobacco products are available to individuals under the age of 18 as provided in Section 1926 (b)(1).**
- **The State will conduct annual, random unannounced inspections as prescribed in Section 1926 (b)(2).**

VII. Treatment Services for Pregnant Women, Section 1927

The State "…will ensure that each pregnant woman in the State who seeks or is referred for and would benefit from such services is given preference in admission to treatment facilities receiving funds pursuant to the grant."

VIII. Additional Agreements, Section 1928

- **Improvement of Process for Appropriate Referrals for Treatment, Section 1928(a)**
- **Continuing Education, Section 1928(b)**
- **Coordination of Various Activities and Services, Section 1928(c)**
- **Waiver of Requirement, Section 1928(d)**

IX.	**Submission to Secretary of Statewide Assessment of Needs, Section 1929**
X.	**Maintenance of Effort Regarding State Expenditures, Section 1930**
	With respect to the principal agency of a State, the State "will maintain aggregate State expenditures for authorized activities at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant."
XI.	**Restrictions on Expenditure of Grant, Section 1931**
XII.	**Application for Grant; Approval of State Plan, Section 1932**
XIII.	**Opportunity for Public Comment on State Plans, Section 1941**
	The plan required under Section 1932 will be made "public in such a manner as to facilitate comment from any person (including any Federal person or any other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.
XIV.	**Requirement of Reports and Audits by States, Section 1942**
XV.	**Additional Requirements, Section 1943**
XVI.	**Prohibitions Regarding Receipt of Funds, Section 1946**
XVII.	**Nondiscrimination, Section 1947**
XVIII.	**Services Provided By Nongovernmental Organizations, Section 1955**
	I hereby certify that the State or Territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act, as amended, as summarized above, except for those Sections in the Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

State: Rhode Island

Name of Chief Executive Officer or Designee: Dr. Ellen R. Nelson

Signature of CEO or Designee:

Title: Director, MHRH **Date Signed:**

If signed by a designee, a copy of the designation must be attached

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

(a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;

(b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

(c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and

(d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, In eligibility, and Voluntary Exclusion – Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with sub-grantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 45 CFR Part 76 by:

(a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dis-pensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;

(b) Establishing an ongoing drug-free awareness program to inform employees about –
(1) The dangers of drug abuse in the workplace;
(2) The grantee's policy of maintaining a drug-free workplace;
(3) Any available drug counseling, rehabilitation, and employee assistance programs; and
(4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

(c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;

(d) Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will –
(1) Abide by the terms of the statement; and
(2) Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

(e) Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

(f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted –

(1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or

(2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

(g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management
Office of the Assistant Secretary for Management and Budget
Department of Health and Human Services
200 Independence Avenue, S.W., Room 517-D
Washington, D.C. 20201

3. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

(1)No Federal appropriated funds have been paid or will be paid, by or on behalf of the under signed, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities, "in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE Director, MHRH
APPLICANT ORGANIZATION RI Dept. of Mental Health Retardation, & Hospitals	DATE SUBMITTED

DISCLOSURE OF LOBBYING ACTIVITIES

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure.)

1. **Type of Federal Action:**	2. **Status of Federal Action**	3. **Report Type:**
☐ a. contract b. grant c. cooperative agreement d. loan e. loan guarantee f. loan insurance	☐ a. bid/offer/application b. initial award c. post-award	☐ a. initial filing b. material change **For Material Change Only:** Year _____ Quarter _____ date of last report

4. **Name and Address of Reporting Entity:**	5. **If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime:**
☐ Prime ☐ Subawardee Tier _____ , if known: _____ **Congressional District**, *if known:* _____	 **Congressional District**, *if known:* _____
6. **Federal Department/Agency:**	7. **Federal Program Name/Description:** **CFDA Number**, *if applicable:* _____
8. **Federal Action Number,** if known:	9. **Award Amount,** if known: $
10. **a. Name and Address of Lobbying Entity** *(if individual, last name, first name, MI):*	**b. Individuals Performing Services** *(including address if different from No. 10a.) (last name, first name, MI):*
11. **Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.**	**Signature:** _____ **Print Name:** _____ **Title:** _____ **Telephone No.:** _____ **Date:** _____

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DISCLOSURE OF LOBBYING ACTIVITIES
CONTINUATION SHEET

Reporting Entity: **Page** **of**

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime Federal recipient, at the initiation or receipt of a covered Federal action, or a material change to a previous filing, pursuant to title 31 U.S.C. Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered Federal action. Use the SF-LLL-A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered Federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered Federal action.

2. Identify the status of the covered Federal action.

3. Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered Federal action.

4. Enter the full name, address, city, state and zip code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants and contract awards under grants.

5. If the organization filing the report in item 4 checks “subawardee”, then enter the full name, address, city, state and zip code of the prime Federal recipient. Include Congressional District, if known.

6. Enter the name of the Federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation, United States Coast Guard.

7. Enter the Federal program name or description for the covered Federal action (item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans, and loan commitments.

8. Enter the most appropriate Federal identifying number available for the Federal action identified in item 1 [e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract, grant, or loan award number; the application/proposal control number assigned by the Federal agency]. Include prefixes, e.g., ‘‘RFP-DE-90-001.’’

9. For a covered Federal action where there has been an award or loan commitment by the Federal agency, enter the Federal amount of the award/loan commitment for the prime entity identified in item 4 or 5.

10. (a) Enter the full name, address, city, state and zip code of the lobbying entity engaged by the reporting entity identified in item 4 to influence the covered Federal action.

    (b) Enter the full names of the individual(s) performing services, and include full address if different from 10(a). Enter Last Name, First Name, and Middle Initial (MI).

11. Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (item 4) to the lobbying entity (item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

ASSURANCES – NON-CONSTRUCTION PROGRAMS

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L.88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE Director, MHRH
APPLICANT ORGANIZATION RI Dept. of Mental Health Retardation, & Hospitals	DATE SUBMITTED

Rhode Island

Goal #1: Continuum of Substance Abuse Treatment Services

GOAL # 1. The State shall expend block grant funds to maintain a continuum of substance abuse treatment services that meet these needs for the services identified by the State. Describe the continuum of block grant-funded treatment services available in the State (See 42 U.S.C. 300x-21(b) and 45 C.F.R. 96.122(f)(g)).

FY 2004 (Compliance):

FY 2006 (Progress):

FY 2007 (Intended Use):

Goal #1. The State shall expend block grant funds to maintain a continuum of substance abuse treatment services that meet these needs for the services identified by the State. Describe the continuum of block grant-funded treatment services available in the State (See 42 U.S.C. 300x-21 (b) and 45 C.F.R. 96.122 (f) (g)).

Needs Assessment

The Department of Mental Health, Retardation and Hospitals, Division of Behavioral Healthcare Services (hereafter referred to as the State or the SSA) expends the SAPT Block Grant funds to support and maintain a continuum of substance abuse treatment services for adolescents and adults in need of treatment for alcohol and drug dependence and addiction. The continuum includes detoxification services, outpatient services and residential treatment.

DBH continues to utilize the results of the needs assessment in its own grant seeking activities, and routinely shares data with community based agencies seeking prevalence data and preparing funding requests which require justification of need. Information will continue to be shared with other state agencies who mutually serve individuals affected by substance abuse (e.g., Corrections, Health, DCYF, Judicial and Human Services, as well as the "Governor's Council on Behavioral Health", whose membership is comprised of all State Departments, provider agencies (both mental health and substance abuse), legislators, judicial representatives and consumers. It is expected that the results of these studies will be utilized for a wide variety of planning activities, including future Block Grant expenditures, budget hearings, legislative hearings, media requests, academia and requests from community-based agencies and individuals.

As in past years, service allocation planning will take into account a number of assessment mechanisms, including use of needs assessment results, continuation of historical funding, block grant set-aside requirements and emerging trends.

Allocation of future federal and state funding will be determined based on STNAP results, other ad hoc reviews, newly emerging issues, examining client utilization data, and utilizing other existing resources wherever possible to maximize available dollars.

Detoxification Services

The State has a single contractor for statewide detoxification services. The current contractor sub-contracts for secure beds with 24 hour surveillance to address the needs of high-risk patients needing detoxification services. The contract, global capacitated at – risk, specifies that detoxification services must be provided on demand. For contract monitoring purposes, this means a client must be admitted within 48 hours of requesting service. The detoxification service accepts clients in need of detoxification from alcohol, opiates and/or benzodiazepines. Also our State system allows for the use of short-term outpatient opioid detoxification using methadone.

In FFY 2007, the SSA will be combining the acute psychiatric hospitalization and detoxification services into a single service providing short-term hospitalization for persons experiencing an acute psychiatric episode and short-term inpatient treatment for persons in need of detoxification from alcohol, opiates, and/or benzodiazepines. The combined service will integrate the services and skills currently present in the now-separate acute psychiatric hospitalization and detoxification services. The contract will call for utilization of evidence based practices and include a requirement for the provision of interim care. This new entity will be fully co-occurring competent and compliant with the State's recently promulgated integrated behavioral healthcare standards. The new entity will continue to prioritize pregnant women and women with dependent children for admission.

General Outpatient Program

The General Outpatient Program (GOP) provides drug free outpatient services for alcohol and drug dependent and addicted persons. The GOP was reorganized in 2004 with five prime contractors organizing services for their respective service areas which encompass general outpatient, intensive outpatient and partial hospitalization levels of care. These programs offer skilled treatment services, which may include individual and group therapy, toxicology, and case management. Such services are provided in an amount, frequency and intensity appropriate to the client's need, which should be delineated in the individualized treatment plan. Co-occurring treatment needs are addressed simultaneously in an integrated manner with psychotropic medication treatment, psychiatric evaluation, psychological assessment, psycho education and twenty-four hour crisis services on site or through consultation. Pregnant women and women with dependent children are prioritized for admission.

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The State funds residential treatment services for adults. The adult residential treatment system ranges from short-term (30 days) to long-term care and includes working, half-way houses. Some of the residential providers base treatment on the Therapeutic Community (TC) which is an intensive and comprehensive treatment model that includes mental health services, family therapy and substance abuse education, and educational and vocational services. Treatment is provided in both individual and group therapy. Pregnant women and women with dependent children are prioritized for admission. Three of the adult residential providers are women-only facilities.

Opioid Treatment Programs (OTP)

The SSA functions as the state Methadone Treatment Authority. The SSA funds nine of the fourteen authorized OTP programs in the state. Funded treatment slots have been geographically dispersed to programs throughout the state to increase treatment accessibility for patients. Opioid Treatment Programs are expected to incorporate best practices based on SAMHSA's TIP 43. For opioid dependent patients who require a higher level of care, dual enrollment is available for both residential and more intensive outpatient services. Pregnant women and women with dependent children are prioritized for admission.

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Job functions, chores and other facility management responsibilities that help maintain the daily operations are used as a vehicle for teaching self development for the clients, although staff members provide supervision and evaluation. The sense of community is integral to the residential setting. The community's role is crucial to the adolescent's treatment because the therapeutic community acts as a family. Our programs are conducted in three stages: induction, primary treatment, and preparation for separation from the therapeutic community. The average stay in residential services is 6 months to one year.

Goal #1. The State shall expend block grant funds to maintain a continuum of substance abuse treatment services that meet these needs for the services identified by the State. Describe the continuum of block grant-funded treatment services available in the State (See 42 U.S.C. 300x-21 (b) and 45 C.F.R. 96.122 (f) (g)).

Needs Assessment

The Department of Mental Health, Retardation and Hospitals, Division of Behavioral Healthcare Services (hereafter referred to as the State or the SSA) expends the SAPT Block Grant funds to support and maintain a continuum of substance abuse treatment services for adolescents and adults in need of treatment for alcohol and drug dependence and addiction. The continuum includes detoxification services, outpatient services and residential treatment.

DBH continues to utilize the results of the needs assessment in its own grant seeking activities, and routinely shares data with community based agencies seeking prevalence data and preparing funding requests which require justification of need. Information will continue to be shared with other state agencies who mutually serve individuals affected by substance abuse (e.g., Corrections, Health, DCYF, Judicial and Human Services, as well as the "Governor's Council on Behavioral Health", whose membership is comprised of all State Departments, provider agencies (both mental health and substance abuse), legislators, judicial representatives and consumers. It is expected that the results of these studies will be utilized for a wide variety of planning activities, including future Block Grant expenditures, budget hearings, legislative hearings, media requests, academia and requests from community-based agencies and individuals.

As in past years, service allocation planning will take into account a number of assessment mechanisms, including use of needs assessment results, continuation of historical funding, block grant set-aside requirements and emerging trends.

Allocation of future federal and state funding will be determined based on STNAP results, other ad hoc reviews, newly emerging issues, examining client utilization data, and utilizing other existing resources wherever possible to maximize available dollars.

Detoxification Services

The State has a single contractor for statewide detoxification services. The current contractor sub-contracts for secure beds with 24 hour surveillance to address the needs of high-risk patients needing detoxification services. The contract, global capacitated at – risk, specifies that detoxification services must be provided on demand. For contract monitoring purposes, this means a client must be admitted within 48 hours of requesting service. The detoxification service accepts clients in need of detoxification from alcohol, opiates and/or benzodiazepines. Also our State system allows for the use of short-term outpatient opioid detoxification using methadone.

In FFY 2007, the SSA will be combining the acute psychiatric hospitalization and detoxification services into a single service providing short-term hospitalization for persons experiencing an acute psychiatric episode and short-term inpatient treatment for persons in need of detoxification from alcohol, opiates, and/or benzodiazepines. The combined service will integrate the services and skills currently present in the now-separate acute psychiatric hospitalization and detoxification services. The contract will call for utilization of evidence based practices and include a requirement for the provision of interim care. This new entity will be fully co-occurring competent and compliant with the State's recently promulgated integrated behavioral healthcare standards. The new entity will continue to prioritize pregnant women and women with dependent children for admission.

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Rhode Island

Goal #2: 20% for Primary Prevention

GOAL # 2. An agreement to spend not less than 20 percent on primary prevention programs for individuals who do not require treatment for substance abuse, specifying the activities proposed for each of the six strategies (See 42 U.S.C. 300x-22(b)(1) and 45 C.F.R. 96.124(b)(1)).

FY 2004 (Compliance):

FY 2006 (Progress):

FY 2007 (Intended Use):

GOAL #2

-An agreement to spend no less than 20 percent on primary prevention programs for individuals who do not require treatment for substance abuse, specifying the activities proposed for each of the six strategies.

FFY 2004 (Compliance):

FFY 2004
PREVENTION COMPLIANCE REPORT

The overall goal of the Department of Mental Health, Retardation and Hospitals (MHRH), Division of Behavioral Healthcare (DBH), the Single State Authority (SSA), is to prevent and reduce ATOD abuse and related unhealthy behavior through the development of a focused, comprehensive, and integrated statewide prevention system.

The primary objective for FY 2004 was to continue development of an infrastructure to support community-based prevention interventions. The Department continued the process that would result in the adoption of a statewide framework for prevention which includes goals, the basic structure and strategies to be used to reach the goals and a description of the roles of various prevention providers in reaching identified goals.

In order to achieve this objective, the Department worked closely with CSAP and its technical assistance contractor, other State agencies, and with community prevention providers. In FY 2004, the Department focused on planning and developing several key components of a state prevention system including: identifying performance outcome measures; implementing an integrated management information system for prevention; finalizing prevention program standards; and workforce development including certification of prevention professionals. Also, as the lead agency associated with the State Incentive Grant, the Department continued to provide leadership in the development of a collaborative statewide prevention plan.

INITIATIVES TO IMPROVE AND ENHANCE THE STATE'S COMPREHENSIVE PREVENTION SYSTEM

1. The Department through the State Incentive Grant continued to develop an enhanced statewide prevention system.

2. The Department continued the process initiated with technical assistance from CSAP to establish prevention program standards that will apply to all prevention programs funded by the Department. During FY 2004 revisions were made to previous drafts of

the proposed prevention standards based on input from Department staff, NECAPT, and NPNs from other State substance abuse agencies

3. The Department continued to implement and expand a web-based Performance Based Prevention System (PBPS) to track prevention service data and program outcomes.

4. The Department continued to collaborate with the Northeast CAPT to convene state leaders in the development of a comprehensive statewide plan to strengthen prevention and reduce youth substance abuse as a component of the SIG.

5. The Department continued to use as its framework CSAP'S Model Programs and current research on science-based programs for the allocation of prevention funds.

6. The Department continued to contract with the University of RI's Community Research and Services Team (CRST) to examine the Voluntary Performance Outcome Measures of the SAPT Block Grant and the human and material resources the Department will need to comply in the future.

INFORMATION MANAGEMENT SYSTEM

The Department implemented a management information system in FY 2002 to track prevention services. The system chosen was a web-enabled system developed by KIT Solutions called the Performance Based Prevention System (PBPS). The PBPS allows providers to track prevention services for both single events and recurring services. It also includes a planning module that is in alignment with the risk and protective factor framework presently used by the Department. During FY 2004, the Department collaborated with KIT Solutions to modify the PBPS from an activity-based system to an outcome-based system. The objectives required in the planning module are based on achieving intermediate and outcome objectives rather than on tracking individual activities. Providers are required to provide documentation of incidence, prevalence, and risk factor levels which informed their selection of outcome and intermediate objectives. The Department regularly provided training on the use of PBPS to all funded prevention providers. During FY 2004, prevention and technical support staff from the Department worked with KIT Solutions to incorporate an objective builder into the planning module to make constructing objective statements easier for providers. The Department also adopted the latest technology available from KIT Solutions, advancing from a web-enabled system to a full web-based system. This new system was implemented in July of 2003.

NOTE: For more detailed information see RESP034 Planning, 1. Needs Assessment

CAPACITY BUILDING/WORKFORCE DEVELOPMENT

During FY 2004, the Department continued initiatives to enhance the capacity of community providers as well as state prevention staff to improve statewide outcomes via effective planning, use, and evaluation of evidence-based prevention strategies. Capacity building activities were focused on three interrelated areas: professional development of Department staff; organizational change; and prevention system refinement.

The Department collaborated with the New England Institute of Addictions Studies, the Center of Substance Abuse Prevention, and the NE CAPT to implement the Fourth Annual School of Prevention Studies.

The Department continued to implement the Achieving Outcomes Plus model for science-based planning, evaluation and continuous quality improvement with providers.

The Department continued to fund the Drug and Alcohol Treatment Association of Rhode Island, a nationally recognized prevention and treatment training system. (See Education B1)

Prevention Program Standards continued to be developed that would establish minimum requirements for professional prevention staff, which will include prevention certification according to ICRC standards.

The Department built upon the series of regional State Incentive Grant Community Readiness Trainings conducted February 2-6, 2003 by the NECAPT and SIG program staff. In FY 2004 the Department provided trainings and technical assistance to funded SIG sub-recipients designed to assist in implementation of evidence-based programming and sustainability planning post-SIG.

COLLABORATION

1. Rhode Island's prevention community has long been concerned about collecting reliable municipal level data and continues to collaborate with other state agencies, and via the recommendations in the SIG Statewide Substance Abuse Prevention Plan, to advocate for an improved youth surveillance system.

   The SIG Youth Development Advisory Committee (YDAC) continued to be vocal advocates for a surveillance system that provides data necessary for state and local substance abuse prevention planning. It was recommended to the Children's Cabinet that this is a critical policy issue deserving of their attention and resources. The YDAC requested that the Children's Cabinet, through the Statewide Substance Abuse Prevention Plan, to adopt the following draft recommendation:

"*Establish a coordinated system for the routine collection of youth-focused data that includes collection of local level data relevant to risk or protective factors for substance abuse and which also provides data that are adequate for state agencies to conduct programmatic prevention planning and policy development."*

2. The Department continued to participate in the ad-hoc Student Health Survey Committee with representatives from the Department of Education and Department of Health. This ad-hoc committee was formed to advocate for a centralized, accessible youth surveillance and data collection system meeting the needs of multiple state agencies. .

3. Accomplishments in FY 2004 included:
   - Dissemination of $2.5 million dollars in State Incentive Grant funds to 25 community providers to implement evidence based national model and locally developed prevention programs.
   - Collaboration with sister agencies and community partners to complete a Statewide Substance Abuse Prevention Plan for the Governor's Children's Cabinet. The plan was presented to the members September 8, 2004
   - Facilitation of the completion of Phase I of an Interdepartmental Prevention Funding Stream Analysis. The analysis was presented to the members of the Children's Cabinet September 8, 2004

NOTE: For more detailed information see RESP034, Prevention State Planning, 2. Involvement of Other …

PREVENTION ACTIVITIES BY STRATEGY CATEGORY

During FY 2004, the Department funded activities within each of the six prevention strategy categories under the guiding principle of promoting comprehensive, multi-component prevention interventions.

A. INFORMATION DISSEMINATION

In FY 2004 ATOD information was disseminated to approximately one million Rhode Islanders, virtually the whole state, from all sectors of the population. This was achieved through the use of Rhode Island's RADAR Network Center, resource directories and help lines, media campaigns and public service announcements.

1. In FY 2004, the Department continued to fund the statewide substance abuse resource center, In-Rhodes.

- Who: The targeted population includes State government offices, community prevention, intervention and treatment service providers, schools, community organizations, and the general public.
- What: In-Rhodes provides the public with timely and innovative educational materials. In-Rhodes is open to the general public and has information and publications for distribution on a variety of substance abuse and other addiction topics. In-Rhodes maintains a library of over 2000 ATOD and AIDS related materials, videos and books; as well as a reference library of over 4,000 documents. Bulk materials are provided to professionals and the general public. In-Rhodes acts as the State RADAR Network Center.
- When: Ongoing
- Where: State of Rhode Island
- How: Direct service provision and formal and informal collaboration with various state and local entities.

2. Resource Directories/Help lines

- Who: The target population is the community at large and those in need of referral services.
- What: The Department continued to support the updating and publishing of a statewide directory of ATOD related providers. The Department also funds the same community agency to provide a 24-hour help-line for referral to treatment agencies and support groups.
- When: Ongoing
- Where: State of Rhode Island
- How: Continuing funding contracts to private, non-profit agency.

B. EDUCATION

1. Drug and Alcohol Treatment Association (DATA) of Rhode Island

- Who: ATOD professionals, human service providers, health care providers, community coalition members.
- What: A core component of the State's prevention and treatment system is the statewide training system. The Department continued to contract with the Drug and Alcohol Treatment Association of Rhode Island (DATA) to oversee the statewide training system. DATA trains approximately 2000 individuals annually and continues to increase minority representation at training. Trainings offered by DATA support the certification of Chemical Dependency Professionals (CDP's), Prevention Specialists, and Student Assistance Counselors. Additional training and workshops were provided to the statewide network of Rhode Island Substance Abuse Prevention (RISAPA) task forces.

  A key initiative of the Department is the development and support of a trained prevention workforce. The Department continued to expand training

opportunities, especially as these trainings support the certification of prevention and student assistance specialists. Contracts issued to block grant recipients and the RISAPA task forces included the requirement that the person responsible for prevention program planning and implementation attend three trainings determined by the Department to be relevant to the development of a comprehensive, science-based prevention system.

To facilitate compliance with block grant requirements, special emphasis continued to be placed on providing AIDS and TB specific training to substance abuse and mental health prevention, intervention and treatment providers as well as to other human service professionals.

The Department and DATA are represented on the Board of Directors of the New England Institute of Addiction Studies (NEIAS) and assist in the coordination of the training initiatives sponsored by NEIAS. The Department participated in the planning of the Fourth Annual New England School of Prevention Studies and continued to offer scholarships to NEIAS training. The Department is also represented on the Northeast Center for Advanced Prevention Technology (CAPT).

The Department continued to promote its training activities through the maintenance of extensive mailing lists and training catalogues.

- When: Ongoing
- Where: State of Rhode Island
- How: Direct service provision, continuation contract with a private non-profit agency, collaboration with community coalitions and professional organizations.

EACH OF THE FOLLOWING IS A COMMUNITY BASED-EDUCATION PROGRAM

1. Child & Family Services of Newport County – Demonstration Project

   - Who: In FY 2004 188 seventh grade students in Newport and 232 seventh grade students in Portsmouth received Life Skills Training, and the Strengthening Families Program served 21 individuals.
   - What: A demonstration project, which combines replications of the universal interventions, Life Skills Training; Strengthening Families Program
   - When: School Year
   - Where: Newport, Rhode Island
   - How: Funding through a competitive RFP process.

2. Initiatives for Human Development – Demonstration Project

   - * Who: In FY 2004 160 seventh graders in one middle school in Cranston received Project Northland and 14 families (20 parents and 14 youth) received the Strengthening Families Program.

- What: A demonstration project, which combines replications of the universal interventions, Project Northland; Strengthening Families Program
- When: School year
- Where: Cranston, Rhode Island
- How: Funding through a competitive RFP process.

3. Phoenix Houses of New England – Demonstration Project

- * Who: In FY 2004 70 seventh grade students in one middle school in Narragansett received Life Skills Training and 2 families (3 parents and 3 youth) received the Strengthening Families Program.
- What: A demonstration project, which combines replications of the universal interventions, Life Skills Training; Strengthening Families Program
- When: School year
- Where: Narragansett, Rhode Island
- How: Funding through a competitive RFP process.

4. Rhode Island Employee Assistance Program (RIEAP) – Demonstration Project

- Who: In FY 2004 564 seventh grade students in three schools in the communities of South Kingstown and West Warwick received Project Northland and 83 individuals received the Strengthening Families Program.
- What: A demonstration project, which combines replications of the universal interventions, Project Northland and the Iowa Strengthening Families Program (ISFP)
- When: School year
- Where: South Kingstown and West Warwick, Rhode Island
- How: Funding through a competitive RFP process.

5. Rhode Island Youth Guidance Center – Demonstration Project

- * Who: In FY 2004 235 seventh grade students in one middle school in Central Falls received Life Skills Training.
- What: A demonstration project, which combines replications of the universal interventions, Life Skills Training and the Iowa Strengthening Families Program (ISFP)
- When: School year
- Where: Central Falls, Rhode Island
- How: Funding through a competitive RFP process.

6. Capital City Community Centers (formerly Smith Hill Center) – Local Initiative

- Who: In FY 2004 1,170 Middle School age children in grades 6-8 in 4 middle schools in Providence received Life Skills Training
- What: Life Skills Training (LST), a science-based model program
- When: School year
- Where: Providence, Rhode Island
- How: Funding through a competitive RFP process.

7. Initiatives for Human Development – Local Initiative

- Who: In FY 2004 43 low literacy parents received the "Parent are Teachers" program
- What: Parents are Teachers (PAT), a CSAP 2001 "promising program" at Dorcas Place, an adult literacy center in Providence. Components of the program include an experiential 15 session parenting curriculum for immigrants who have low literacy skills
- When: Ongoing
- Where: Providence, Rhode Island
- How: Funding through a competitive RFP process.

8. Socio-Economic Development Center for Southeast Asians – Local Initiative

- Who: In FY 2004 125 (78 adults and 47 youth) at-risk Laotian and Cambodian individuals and families in Rhode Island
- What: The Laotian and Cambodian Substance Abuse Prevention Program provides culturally appropriate and innovative alcohol and other drug abuse and prevention education and assistance that will strengthen the process of helping through a culturally appropriate teaching, mentoring, and supportive case management approach.
- When: Ongoing
- Where: The state of Rhode Island
- How: Funding through a competitive RFP process.

EACH OF THE FOLLOWING REPRESENTS A COMPREHENSIVE, MULTI-COMPONENT PREVENTION PROGRAM.

9. Central Falls Family Self-Sufficiency Foundation – Local Initiative

- Who: In FY 2004 100 low income individuals (50 parents and 50 youth) in Central Falls, with particular emphasis on families living in public housing, received the "Dare To Be You" program
- What: Dare to be You

- When: Ongoing
- Where: Central Falls, Rhode Island
- How: Funding through a competitive RFP process.

10. Initiatives for Human Development – Local Initiative (Education, Alternatives, Community Process)

    - Who: In FY 2004 226 Rhode Island Middle School and High School youth attended the Rhode Island Teen Institute.
    - What: The Rhode Island Teen Institute is a comprehensive prevention program targeting positive and negative peer leaders of secondary school age. Using a cross-peer model, RITI is designed to maximize the impact of prevention on the youth of Rhode Island by identifying peer leaders in a broad range of community settings, enhancing their leadership skills, reinforcing or fostering their commitment to wellness, and training them to organize their peers to work for prevention in their own community.
    - When: Ongoing
    - Where: State of Rhode Island
    - How: Funding through a competitive RFP process.

11. New Visions for Newport County, Inc. – Local Initiative (Education, Info. Dissemination, Alternatives, Community Process)

    - Who: In FY 2004 36 At-risk youth ages 14-18 in Newport received services through the New Ventures program and 13 youth attended the New Ventures Career Camp.
    - What: The "New Ventures Substance Abuse Prevention Program" provides weekly educational groups, job skills training, career guidance, college placement assistance, and cultural activities. There is a Summer Career Camp program to strengthen life and job skills and receive information on substance abuse prevention, HIV/AIDS, conflict resolution and career development. There is also a parent involvement component.
    - When: Ongoing
    - Where: Newport, Rhode Island
    - How: Funding through a competitive RFP process**.**

12. Rhode Island Youth Guidance Center – Local Initiative (Education, Alternatives)

    - Who: In FY 2004 54 students in grades 5 through 8 in the cities of Pawtucket and Central Falls received services through the A+ Adventure Program
    - What: The A+ Adventure Program, a multi-disciplinary, risk-focused school-based after-School program combines educational enrichment, recreation, the

arts, and a structured behavioral orientation in building skills and changing attitudes that contribute to successful outcomes in adolescence.
- When: School year
- Where: Pawtucket and Central
- How: Funding through a competitive RFP process.

13. Tri-Town Community Action Agency – Local Initiative

- Who: In FY 2004 38 families (70 individuals) received Dare to be You and 27 families (62 individuals) received Creating Lasting Family Connections.
- What: Dare to be You; Creating Lasting Family Connections
- When: Ongoing
- Where: Johnston, Smithfield, Foster, Glocester, and Burrillville, Rhode Island
- How: Funding through a competitive RFP process.

NOTE:* The Department continuously monitors the provision of its funded prevention, intervention, and treatment services through on-site monitoring, electronic transfer of client data, and through monthly data submission as required of all prevention providers. Through the PBPS, the Department is able to run data reports on demand. In addition, PBPS routinely generates annual reports at the provider and State level. Prevention providers utilize these reports to assess the degree to which they met their identified outcome and intermediate objectives for their targeted populations. If data indicate that participant/activity targets projected are not being met the Department contacts providers to determine what factors may be impacting the program. In some cases targets may be inflated and need to be revised, and in others a plan for outreach or other strategies may be developed.

C. ALTERNATIVES

In FY 2004, as a matter of policy, the Department did not fund, through contracts, "free-standing" alternatives programs. The Department prefers to fund comprehensive prevention programs in which healthy alternative activities may be offered in conjunction with other components (usually focused on skill-building). The following are examples of services/activities offered under this strategy (alternatives) as part of a comprehensive prevention program (see detailed descriptions above).

- Central Falls Family Self-Sufficiency Foundation – Local Initiative (see B9)
- Initiatives for Human Development – Local Initiative (see B10)
- New Visions for Newport County, Inc. – Local Initiative (see B11)
- Rhode Island Youth Guidance – Local Initiative (see B12)
- Tri-Town Community Action Agency – Local Initiative (see B13)

D. EARLY IDENTIFICATION AND REFERRAL

The Student Assistance Program continued to provide early identification and referral services.

1. Rhode Island Student Assistance Program

- Who: Students at 21 senior high schools and 25 middle and junior high schools, and their families. Approximately 7,500 students were be served during FY 2004.
- What: The Department focuses its early identification and referral efforts associated with the Block Grant on Student Assistance Programs (SAP) for approximately 26 of the State's senior high schools. Rhode Island follows the Westchester County model for SAP's.

  Three contractors (R.I. Employee Assistance, CODAC, and Child & Family Services of Newport County) provide student assistance services within high school and junior high/middle school settings. The student assistance provider agencies place a trained, master's level Student Assistance Counselor in each school 2 ½ to 5 days per week depending on the size of the school. Student Assistance Counselors do assessment and conduct individual and group educational sessions for students determined to be at-risk for alcohol, drug, school, family, peer or other personal problems.

  During FY 2004 the SAP providers implemented a uniform set of core indicators and measures to evaluate program effectiveness.
- When: School year
- Where: State of Rhode Island
- How: Non-competitive contracts with four community service providers who have staff qualified to implement the Westchester County Student Assistance Model.

E. COMMUNITY-BASED PROCESS

Community-based Process activities are funded with State General Revenue administered by the Department. The description below is provided for informational purposes.

1. Rhode Island Substance Abuse Prevention Act (RISAPA) Municipal Task Forces
   Task forces are funded through state legislative appropriations totaling over $1 million annually.

- Who: 35 substance abuse prevention task forces (community coalitions)
- What: The key community based primary prevention initiative sponsored by the Department continued to support the statewide network of community-based substance abuse prevention coalitions, called task forces. Task forces

have as their primary responsibility the development and implementation of comprehensive prevention plans for their respective communities, which are based on the results of community needs assessment. Task forces are the primary vehicle by which the State implements environmental strategies, not only by the Department, but across State agencies (especially in the areas of tobacco control and violence prevention). Task forces are represented on the SIG Statewide Prevention Planning Committee and work closely with the Enforcing Underage Drinking Laws initiative, particularly focusing their efforts on changing community norms, policies and ordinances.

- When: Ongoing
- Where: State of Rhode Island
- How: Continuation contracts with local municipalities

2. The Department co-sponsors and/or is represented on the advisory board for numerous prevention-related initiatives statewide.

F. ENVIRONMENTAL

Environmental Strategies are funded with State General Revenue and a formula grant from the U.S. Office of Juvenile Justice and Delinquency Prevention. The description below is provided for informational purposes.

1. During FY 2004, the Rhode Island Substance Abuse Prevention Act (RISAPA) Municipal Task Forces continued to be the primary vehicle by which the State implements environmental strategies (see E1 above).

2. During FY 2004, a major priority of Department in the area of environmental strategies was to reduce the non-compliance rate of commercial alcohol sales to underage youth. As the administrative agency for the OJJDP Enforcing the Underage Drinking Laws Program, the Department:

   - conducted the 4th annual Alcohol Purchase Survey to determine compliance with the state statute on alcohol sales to underage persons. The FFY 2004 survey showed an 81.9% vendor compliance rate.
   - continued to involve and work with the R.I. State Police, municipal police departments, and community task forces to reduce the non-compliance rate in FY 2004.
   - continued to focus on reducing noncommercial supply of alcohol to underage persons. The Department developed a plan to mobilize community efforts to advocate for changes in current state statutes to address Social Host Liability.
   - Convened the Enforcing the Underage Drinking Laws Statewide Advisory committee continued to meet on a quarterly basis and examine policy issues relevant to reducing youth access to and use of alcohol. FY 2004 efforts

focused on Social Host Liability, increasing penalties for minors in possession including mandatory substance abuse assessments for repeat offenders, and a technical amendment to the Keg Registration Law.

- The Department continued to collaborate with the State Police and municipal police departments to increase enforcement of underage drinking laws and tobacco control laws.
- The Department continued to collaborate with the Governor's Highway Safety Office and the Traffic Safety Coalition to implement programs to reduce accidents and death related to drugs, including alcohol, and driving.

In FY 2004 there was passage of a mandatory alcohol server training law that requires any person who serves alcohol or checks IDs at establishments where alcohol is consumed on premises be required to complete a qualifying training program every 5 years.

In FY 2004 there was also, passage of a law to increase penalties to minors found to be in possession of alcohol. New penalties include increased fines, possible community service and mandatory suspension of driver’s license and a possible substance abuse assessment if it is a second offense.

GOAL #2

-An agreement to spend no less than 20 percent on primary prevention programs for individuals who do not require treatment for substance abuse, specifying the activities proposed for each of the six strategies.

FFY 2006
PREVENTION PROGRESS REPORT

The overall goal of the Department of Mental Health, Retardation and Hospitals, Division of Behavioral Healthcare (DBH), the SSA, is to prevent and reduce ATOD abuse and related unhealthy behavior through the development of a focused, comprehensive and integrated statewide prevention system.

The primary objective for FFY 2006 is to continue development of an infrastructure to support community-based prevention interventions. The Department continues the process that will result in the adoption of a statewide framework for prevention, which includes goals, the basic structure and strategies to be used to reach the goals and a description of the roles of various prevention providers in attaining these goals.

In order to achieve this objective, the Department continues to work closely with CSAP and its technical assistance contractor, the SPF SIG, other State agencies and with community prevention providers. In FFY 2006, the Department is focused on planning and developing several key components of a state prevention system including: performance outcome measures; implementation of an integrated management information system for prevention; finalization of prevention program standards; and workforce development including certification of prevention professionals. As the lead agency associated with the State Incentive Grant (SIG 1), the Department continues to provide leadership in the implementation of the previously adopted Statewide Substance Abuse Prevention Plan.

INITIATIVES TO IMPROVE AND ENHANCE THE STATE'S COMPREHENSIVE PREVENTION SYSTEM

The Department through the State Incentive Grant continues to develop an enhanced statewide prevention system.

In addition, the Department is incorporating the steps of the Strategic Prevention Framework (SPF) into its planning process.

The Department continues to work with the Strategic Prevention Framework State Incentive Grant (SPF SIG), which is housed in the Executive Office of Health and Human Services. The Department consulted and advised on the development of the

required state plan and was briefed on the work of the Statewide Epidemiological and Outcomes Workgroup. Also, the Department, in collaboration with the SPF SIG and the Northeast Center for the Advancement of Prevention Technologies (NECAPT), participated in a staff in-service training on the SPF and hosted training on the first two steps of the SPF for municipal taskforces.
As previously stated 25 awards were made under the State Incentive Grant. The Department continues to monitor compliance with the objectives of the SIG and provide TA in conjunction with the NE CAPT.

The Department developed and brought to public hearing on May 13, 2005 proposed Rules and Regulations for the Certification of Prevention Organizations which apply to all organizations funded by MHRH to provide prevention Services. The proposed Rules and Regulations were promulgated in FFY 2006 and will be incorporated into FY 07 contracts for all MHRH-funded prevention providers.

The Department continues to work on refinement of the web-based PBPS to track prevention service data and program outcomes including the development of a module developed, specifically, to capture information about the work of community coalitions. . In 2006, the Department began working with KIT solutions to develop a custom coalition module that will include a logic model/program plan, a capacity plan, an evaluation plan, and a report mechanism that is linked to the logic model. We expect a demo of the new module in September of 2006.

The Department continues to use as its framework the Institute of Medicine's spectrum of preventive interventions and risk and protective factors. The Department also incorporates evidence-based programs, policies, and practices into all of its planning and implementation activities.

The Department continues to collaborate with the University of RI's Community Research and Services Team (CRST) to examine the current Voluntary Performance Outcome Measures of the SAPT Block Grant and the human and material resources the Department will need to comply with reporting requirements in the future

INFORMATION MANAGEMENT SYSTEM

In FFY 2006 our goals for PBPS include revising the format in which we conduct training classes. We are incorporating more of the individual users actual planning data into the class thus providing participants the opportunity to complete those modules with real data.

The Department is working cooperatively with KIT Solutions to make the PBPS compatible with the Strategic Planning Framework State Incentive Grant (SPF SIG) data collection requirements. The Department is also working with KIT Solutions on the development of a module tailored to the needs of community-based coalitions.

NOTE: For more detailed information see RESP034 Planning, 1. Needs Assessment

CAPACITY BUILDING/WORKFORCE DEVELOPMENT

The Department continues initiatives to enhance the capacity of community providers as well as state prevention staff to improve statewide outcomes via effective planning, use, and evaluation of science-based prevention.

The Department collaborated with the New England Institute of Addictions Studies, the Center of Substance Abuse Prevention, and the NE CAPT to implement a 6th Annual School of Prevention Studies.

Through a partnership with CSAP's National Center for the Advancement of Prevention, the Department continues to implement the Rhode Island adaptation of the Pathways to Prevention model, Getting to Prevention Results for science-based planning, evaluation and continuous quality improvement with our providers.

The Department continues to fund the Drug and Alcohol Treatment Association of RI (DATA), a nationally recognized prevention and treatment training system. (see B.1 Education)

The Department continues to collaborate with DATA to develop and offer prevention training, which will meet ICRC requirements for the certification of prevention professionals.

As a follow-up to the regional State Incentive Grant Community Readiness Training and subsequent training conducted by the NECAPT and SIG program staff; the Department conducts training and technical assistance to funded SIG sub-recipients designed to assist in implementation of evidence-based programming and sustainability planning post-SIG.

COLLABORATION

1. Rhode Island's prevention community has long been concerned about collecting reliable municipal level data and continues to collaborate with other state agencies, and via the recommendations in the SIG Statewide Substance Abuse Prevention Plan, to advocate for an improved youth surveillance system.

   The Statewide Substance Abuse Prevention Plan recommends the establishment of a surveillance system that provides data necessary for state and local substance abuse prevention planning. This is a critical policy issue.

   "*Establish a coordinated system for the routine collection of youth-focused data that includes collection of local level data relevant to risk or protective factors for*

substance abuse and which also provides data that are adequate for state agencies to conduct programmatic prevention planning and policy development."

The state epidemiological workgroup (SEOW) from the SPF SIG was established as a workgroup of the Youth Development Advisory Committee. The SEOW core membership is composed of epidemiologists with an expanded membership to include policy makers and data base managers. The SEOW's primary goal is to deliver data driven community profiles within the RI municipalities.

The community profiles developed by the SEOW will be utilized by the Department for planning purposes.

Also, during FFY 2006, the SEOW is conducting a thorough inventory of surveillance, survey and social indicator data sets relevant to substance abuse risk and protective factors.

2. The Department continues to participate in the ad-hoc Student Health Survey Committee with representatives from the Department of Education and Department of Health. This ad-hoc committee was formed to advocate for a centralized, accessible youth surveillance and data collection system meeting the needs of multiple state agencies. This committee continues to build upon the work of the SPPC and the above referenced recommendation.

3. The Department continued to assist the Children's Cabinet by facilitating administrative and technical assistance to the Youth Development Advisory Committee (YDAC). In the last quarter of FFY 2006 this responsibility was transferred to the SPF SIG, which uses the YDAC as its advisory council.

4. Management Coordination between the State Incentive Grant, Strategic Prevention Framework State Incentive Grant, and the Department continues to include regular meetings between the SIG and SPF SIG Project Managers and the Chief of Prevention and Planning. Major foci of this coordinated effort include leveraging SPF and SIG resources, coordinating the planning and delivery of prevention services, and enhancing development of the state infrastructure for prevention services planning and delivery. This group also focuses on joint planning and development of the RI State work plan with Northeast CAPT.

5. The Department continues to participate and collaborate with the Interagency Coordinating Team to decrease duplicative efforts by sharing information and conducting joint planning sessions. Interagency Coordinating Team members are represented on the YDAC workgroups developing strategic plans for the recommendations made in the State Plan.

6. The Department continues extensive collaboration with the Department of Health on a number of issues, particularly maternal and child health issues, implementation

of mechanisms to fulfill the Synar requirements, HIV/TB initiatives, and common legislative issues

7. The Department continues to collaborate with the NECAPT, DATA, the Safe and Drug Free Schools Coordinator, SIG coordinator, SPF SIG coordinator and other sister state agencies to conduct training and technical assistance initiatives to implement evidence-based programs.

RFP FOR RE-ALLOCATION OF FUNDS

The Department is committed to sustaining a prevention system consisting of culturally appropriate science-based programs and best practices, which are organized into comprehensive community-based prevention on the local level, and are supported by coordinated funding and technical assistance from the state level.

As of September 1, 2005, the Department is funding community-based substance abuse prevention programs in response to an RFP issued in March of 2005. This RFP was issued to re-allocate the 20% prevention set-aside to be consistent with the state framework for prevention and CSAP's guidelines for implementing science-based programs. Programs will be within each of the six strategies.

$860,000 was made available through this RFP to fund a number of community-based substance abuse prevention programs. Applicants could propose to implement programs serving:

Universal populations, or
Selected populations including, but not limited to, youth at risk of dropping out of school, recent immigrants, children of substance abusing parents, and the elderly, or
Indicated populations.

Approximately 70% of the available funding was awarded to applicants that proposed to replicate science-based model programs. Approximately 30% of the available funds have been awarded for other programs that have demonstrated success in reducing alcohol, tobacco and other drugs (ATOD) among the target populations.

PREVENTION ACTIVITIES BY STRATEGY CATEGORY

During FFY 2006, the Department continues to fund activities within each of the six prevention strategy categories under the guiding principle of promoting comprehensive, multi-component prevention interventions.

A. INFORMATION DISSEMINATION

During FFY 2006, ATOD information is being disseminated to approximately 1 million Rhode Islanders, virtually the whole state. This is achieved through the use of Rhode Island's RADAR Network Center, help lines, media campaigns and public service announcements. Further detail is provided below:

1. In FFY 2006, the Department continues to fund the statewide substance abuse resource center, In-Rhodes.

    - Who: The targeted population includes State government offices, community prevention, intervention and treatment service providers, schools, community organizations, and the general public.
    - What: In-Rhodes provides the public with timely and innovative educational materials. In-Rhodes is open to the general public and has information and publications for distribution on a variety of substance abuse and other addiction topics. In-Rhodes maintains a library of over 2000 ATOD and AIDS related materials, videos and books; as well as a reference library of over 4,000 documents. Bulk materials are provided to professionals and the general public. In-Rhodes acts as the State RADAR Network Center.
    - When: Ongoing
    - Where: State of Rhode Island
    - How: Direct service provision and formal and informal collaboration with various state and local entities.

2. Help Line/Resource Directory

    - Who: The target population is the community at large and those in need of referral services.
    - What: The Department continues to fund the RI Council on Alcoholism and Other Drug Dependence to develop and disseminate the Directory of RI Substance Abuse Treatment and Prevention services and a 24-hour help-line for referral to treatment agencies and support groups.
    - When: Ongoing
    - Where: State of Rhode Island
    - How: Continuing funding contracts to private, non-profit agency.

B. EDUCATION

Drug and Alcohol Treatment Association (DATA) of Rhode Island

- Who: ATOD professionals, human service providers, health care providers, community coalition members.

- What: A core component of the State's prevention and treatment system is the statewide training system. The Department continues to contract with the Drug and Alcohol Treatment Association of Rhode Island (DATA) to oversee the statewide training system. DATA trains approximately 2000 individuals annually and continues to increase minority representation at training. Trainings offered by DATA support the certification of Chemical Dependency Professionals (CDPs), Prevention Specialists, and Student Assistance Counselors. Additional training and workshops continue to be provided to the statewide network of Rhode Island Substance Abuse Prevention (RISAPA) task forces.

  A key initiative of the Department is the development and support of a trained prevention workforce. The Department continues to expand training opportunities, especially as these trainings support the certification of prevention and student assistance specialists. In FFY 2006 a priority for the Department in collaboration with DATA is to develop and offer prevention trainings, which meet ICRC requirements for the certification of prevention professionals.

  Contracts issued to block grant recipients and the RISAPA-funded task forces/coalitions include the requirement that the person responsible for prevention program planning and implementation attend trainings determined by the Department to be relevant to the development of a comprehensive, science-based prevention system.

  To facilitate compliance with block grant requirements, special emphasis continues to be placed on providing AIDS and TB specific training to substance abuse and mental health prevention, intervention and treatment providers as well as to other human service professionals.

  The Department and DATA are represented on the Board of Directors of the New England Institute of Addiction Studies (NEIAS) and assist in the coordination of the training initiatives sponsored by NEIAS. The Department participated in the planning of the 6th Annual New England School of Prevention Studies and to offer scholarships to NEIAS training. The Department is also represented on the Northeast Center for Advanced Prevention Technology (CAPT).

  The Department continues to promote its training activities through the maintenance of extensive mailing lists and training catalogues.
- When: Ongoing
- Where: State of Rhode Island
- How: Direct service provision, continuation contract with a private non-profit agency, collaboration with community coalitions and professional organizations.

COMMUNITY-BASED PROGRAMS

EACH OF THE FOLLOWING IS A COMMUNITY-BASED EDUCATION PROGRAM

1. Initiatives for Human Development (Education)

   - Who: Low literacy immigrant parents at risk for substance abuse. As of July 31, 2006, 60 immigrant parents have received services.
   - What: "Parents Are Teachers (PAT)" a CSAP 2001 "promising program" at Progreso Latino in Central Falls. Components of the program include an experiential 13 session parenting curriculum; parent/child sessions using homework for extended practice of skills learned during classroom sessions, a Team Leader program to cultivate past PAT participants as peer helpers. It is proposed to implement a fourth component, training of PAT team leaders to be PAT program facilitators able to implement the program independently.
   - When: Ongoing (Contracts began September 1, 2005)
   - Where: Central Falls, Rhode Island
   - How: Funding through a competitive RFP process.

2. Comprehensive Community Action, Inc. (Education)

   - Who: Approximately 200 Head Start and Day Care children age 2-5 and their parents. As of July 31, 2006, 252 individuals have received services.
   - What: "Incredible Years" a Center for Substance Abuse Prevention designated Effective Program The applicant will implement the Incredible Years Training Series including parent skills training and classroom-based child training programs. These program components are designed to promote emotional and social competence and to prevent aggressive, defiant, oppositional and impulsive behavior in young children 2-7 years old.
   - When: Ongoing (Contracts began September 1, 2005)
   - Where: Cranston, Rhode Island
   - How: Funding through a competitive RFP process.

3. Child and Family Services of Newport County (Education)

   - Who: Approximately 212 sixth grade students at Joseph H. Gaudet Middle School in Middletown, RI. As of July 31, 2006, 182 students have received Life Skills Training (LST) and 21 (8 youth and 13 adults) participants have received the Strengthening Families Programs (SFP)
   - What: Life Skills Training (LST) and Strengthening Families Programs (SFP) LST, a three-year comprehensive, interactive prevention program will be offered to all (212) 6th grade students following them through the 8th grade over the course of three years. The program addresses three major components: drug resistance skills, personal self-management, and general social skills. SFP by meeting with a cohort of parents and children provides intensive, interactive and experiential training. The program identifies three major outcome objectives: to improve family relations, increase parenting skills, and increase children's skills.

- When: Academic School Year (Contracts began September 1, 2005)
- Where: Middletown, Rhode Island
- How: Funding through a competitive RFP process.

4. Providence Housing Authority

- Who: Services will be provided to approximately 130 youth at three PHA owned and operated community centers in Providence. As of July 31, 2006, 71 youth age 6-11 have received Life Skills Training, and 37 children and 7 adults have received I Can Problem Solve.
- What: Three age-appropriate model, promising, and effective programs to address the substance abuse prevention education needs of low income, minority youth and their families living in Providence public housing. The programs to be offered are to children and their parents are "I Can Problem Solve" (ICPS) and "ICPS Raising a Thinking Child" as well as an enhancement of the "Life Skills Training" program.
- When: Ongoing (Contracts began September 1, 2005)
- Where: Providence, Rhode Island
- How: Funding through a competitive RFP process.

EACH OF THE FOLLOWING REPRESENTS A COMPREHENSIVE, MULTI-COMPONENT PREVENTION PROGRAM.

5. Initiatives for Human Development – Rhode IslandTeen Institute (RITI)
(Education, Alternatives, Community Process)

- Who: Rhode Island Middle School and High School youth As of July 31, 2006, 161 youth have attended RITI.
- What: Rhode Island Teen Institute (RITI), a comprehensive prevention program targeting positive and negative peer leaders of secondary school age. The primary target is middle school youth. Using a cross-peer model, RITI is designed to maximize the impact of prevention on the youth of Rhode Island by identifying peer leaders in a broad range of community settings, enhancing their leadership skills, reinforcing or fostering their commitment to wellness, and training them to organize their peers to work for prevention in their own community. The proposal seeks to implement 3 residential trainings (2 middle school and 1 high school).
- When: Ongoing (Contracts began September 1, 2005)
- Where: Rhode Island
- How: Funding through a competitive RFP process.

6. Metropolitan Regional Career & Technical Center (Education, Alternatives, Early Identification and Referral)

   - Who: 48 high-risk 9th and 10th grade students at six small schools in Providence. As of July 31, 2006, 51 students have received services.
   - What: "Leadership & Resiliency" program a Center for Substance Abuse Prevention designated Effective Program. The program will provide group activities designed to promote constructive behaviors, discourage ATOD use, and develop social and physical environments that facilitate drug-free life styles. The program consists of the following components: group meetings; individual and small group sessions, referrals, community service, and outdoor education and leadership development.
   - When: Academic School Year (Contracts began September 1, 2005)
   - Where: Providence, Rhode Island
   - How: Funding through a competitive RFP process.

7. Pawtucket Substance Abuse Prevention Task Force (Education, Community Process, Early Identification and Referral)

   - Who: Services will be provided to Pawtucket youth and their families As of July 31, 2006, 16 (7 adults and 9 youth) individuals have received services.
   - What: Creating Lasting Family Connections (CLFC) a Center for Substance Abuse Prevention designated Effective Program. The program will become part of Project FIRST, which will connect CLFC with the Creating Solutions for Independence (CSI) program at Prospect Heights and Galeco Court in Pawtucket. The implementation of the family-based CLFC will create a comprehensive family based program that will see the expansion of services to include parents and family members of youth currently served by CSI.
   - When: Academic School Year (Contracts began September 1, 2005)
   - Where: Pawtucket, Rhode Island
   - How: Funding through a competitive RFP process.

8. Rhode Island Employee Assistance Program, Inc. (RIEAP) (Education, Early Identification and Referral)

   - Who: with 900 students in grades 6-8 at Westerly Middle School As of Date, 2006, 224 students have received services.
   - What: "Project Success" a Center for Substance Abuse Prevention designated Effective Program. Program components include Screening and Assessment of students, an 8 session Prevention Education Series, Individual and Group Counseling using motivational interviewing, Referral, Administrative Strategies, and Clinical Strategies.

- When: Academic School Year (Contracts began September 1, 2005)
- Where: Westerly, RI
- How: Funding through a competitive RFP process.

9. RiverzEdge Arts Project (RAP) (Education, Alternatives)

- Who: Services will be provided to 22 educationally and economically disenfranchised Woonsocket area youth 13-19 years old As of July 31, 2006, 18 youth have attended the Arts Project and 13 are attending the Rap Summer program.
- What: The RiverzEdge Arts Project (RAP) to provide youth with the keys to self-sufficiency through a paid arts apprenticeship that focuses on developing art and business skills, and leadership training, while facilitating improved social skills, work ethics, and team participation. All activities are aimed toward reducing substance abuse behavior and overall at-risk behaviors.
- When: Ongoing (Contracts began September 1, 2005)
- Where: Woonsocket, Rhode Island
- How: Funding through a competitive RFP process.

10. Socio-Economic Development Center for Southeast Asians (Education, Early Identification and Referral))

- Who: Services will be provided to approximately 50 at-risk Laotian and Cambodian individuals and their families As of July 31, 2006, 85 individuals have received services.
- What: An intensive substance abuse prevention program for the Laotian and Cambodian communities in Rhode Island. The applicant will provide culturally appropriate and innovative alcohol and other drug abuse and prevention education and assistance that will strengthen the process of helping individuals and families through a culturally appropriate teaching, mentoring, and supportive case management approach.
- When: Ongoing (Contracts began September 1, 2005)
- Where: Providence, Rhode Island
- How: Funding through a competitive RFP process.

11. Urban League of Rhode Island (Education, Alternatives)

- Who: Services will be provided to teen families that have infant and toddler age children (birth to 24 months) As of July 31, 2006, 23 individuals have received services.
- What: A developer-designed adaptation of “Dare to Be You” a Center for Substance Abuse Prevention designated Effective Program. The adapted “Dare to Be You” will target teen parents, and work with these teen families

that have infant and toddler age children (birth to 24 months). Project objectives include increased self-sufficiency, prevention of repeat pregnancies, reduced use of illicit substances, and improved parenting practices.

- When: Ongoing (Contracts began September 1, 2005)
- Where: Providence, Rhode Island
- How: Funding through a competitive RFP process.

C. ALTERNATIVES

As a matter of policy, the Department does not fund, through contracts, "free-standing" alternatives programs. The Department prefers to fund comprehensive prevention programs in which healthy alternative activities may be offered in conjunction with other components (usually focused on skill-building). The following are examples of services/activities offered under this strategy (alternatives) as part of a comprehensive prevention program (see detailed descriptions in Section B above).

- Initiatives for Human Development – Teen Institute (See B5)
- Metropolitan Regional Career & Technical Center (See B6)
- Pawtucket Substance Abuse Prevention Task Force (See B7)
- RiverzEdge Arts Project (See B 9)
- Urban League of Rhode Island (See B11)

D. EARLY IDENTIFICATION AND REFERRAL

In FFY 2006 the South County Physicians Initiative (SCPI) and the Student Assistance Program provide early identification and referral services.

1. South County Physicians Initiative (SCPI)

- Who: Services are provided to youth, ages 12–22, and their parents during well-child visits to pediatric offices. As of July 31, 2006, 277 individuals have received services.
- What: A pilot project to determine the steps necessary to implement a standardized substance abuse and mental health screening instrument in pediatric offices, and to facilitate education and referral of identified at risk youth to appropriate behavioral healthcare providers. The project is conducted by South Kingston Community Prevention Partnership & Narragansett Youth Task Force in four pediatric/primary care offices/centers in South Kingstown, Narragansett, and North Kingstown.
- When: on-going
- Where: South Kingstown, Narragansett, and North Kingstown, Rhode Island
- How: Non-competitive contract

2. Rhode Island Student Assistance Program

- Who: Students at 21 senior high schools and 25 middle and junior high schools, and their families. It is estimated that approximately 7,500 students will be served during FY 2006.
- What: The Department focuses its early identification and referral efforts associated with the Block Grant on Student Assistance Programs (SAP) for approximately 26 of the State's senior high schools. Rhode Island follows the Westchester County model for SAP's.

  Three contractors (R.I. Employee Assistance, Codac, and Child & Family Services of Newport County) provide student assistance services within high school and junior high/middle school settings. The student assistance provider agencies place a trained, master's level Student Assistance Counselor in each school 2 ½ to 5 days per week depending on the size of the school. Student Assistance Counselors do assessment and conduct individual and group educational sessions for students determined to be at-risk for alcohol, drug, school, family, peer or other personal problems.
- When: School year
- Where: State of Rhode Island
- How: Non-competitive contracts with three community service providers who have staff qualified to implement the Westchester County Student Assistance Model.

E. COMMUNITY-BASED PROCESS

Community-based Process activities are funded with State General Revenue administered by the Department. The description below is provided for informational purposes.

1. Rhode Island Substance Abuse Prevention Act (RISAPA)-fundedMunicipal Task Forces *Task forces are funded through state legislative appropriations totaling over $1 million annually.*

- Who: 35 substance abuse prevention task forces (community coalitions)
- What: The key community based primary prevention initiative sponsored by the Department continued to support the statewide network of community-based substance abuse prevention coalitions, called task forces. Task forces have as their primary responsibility the development and implementation of comprehensive prevention plans for their respective communities, which are based on the results of community needs assessment. Task forces are the primary vehicle by which the State implements environmental strategies, not only by the Department, but across State agencies (especially in the areas of tobacco control and violence prevention). Task forces are represented on the SIG Statewide Prevention Planning Committee and work closely with the

Enforcing Underage Drinking Laws initiative, particularly focusing their efforts on changing community norms, policies and ordinances.

- When: Ongoing
- Where: State of Rhode Island
- How: Continuation contracts with local municipalities

2. The Department co-sponsors and/or is represented on advisory boards for numerous prevention-related initiatives statewide.

F. ENVIRONMENTAL

Environmental Strategies are funded with State General Revenue, a formula grant from the U.S. Office of Juvenile Justice and Delinquency Prevention, and the SIG. The description below is provided for informational purposes.

1. During FY 2006, the Rhode Island Substance Abuse Prevention Act (RISAPA) Municipal Task Forces continued to be the primary vehicle by which the State implements environmental strategies (see E1 above).

2. During FY 2006, a major priority of Department in the area of environmental strategies is to reduce the non-compliance rate of commercial alcohol sales to underage youth. As the administrative agency for the OJJDP Enforcing the Underage Drinking Laws Program, the Department:

   Conducted the 6th annual Alcohol Purchase Survey to determine compliance with the state statute on alcohol sales to underage persons. The FFY 2006 survey showed a 17% vendor violation rate compared to 18.2% violation rate in FY 05.

   Continues to involve and work with the R.I. State Police, municipal police departments, and community task forces to reduce the violation rate in FY 2006.

   Continues to focus on reducing noncommercial supply of alcohol to underage persons. The Department developed a plan to mobilize community efforts to advocate for changes in current state statutes to address Social Host Liability. These advocacy efforts resulted in the passage of legislation that amended the definitions and penalties for procuring alcohol for minors thereby making it a misdemeanor offense to furnish alcohol or otherwise permit the consumption of alcohol by minors. In Fy 07 the focus will be on raising public awareness about these changes through a media campaign targeting parents and young adults.

   Convenes the Enforcing the Underage Drinking Laws Statewide Advisory committee continued to meet on a quarterly basis and examine policy issues relevant to reducing youth access to and use of alcohol. FY 2006 efforts focus

on Social Host Liability, increasing penalties for minors in possession including mandatory substance abuse assessments for repeat offenders, and a technical amendment to the Keg Registration Law.

Continues to collaborate with the State Police and municipal police departments to increase enforcement of underage drinking laws and tobacco control laws.

Works closely with the Governor's Office and the Family Court to make recommendations to address the problematic issue of drinking and driving.

Continues to collaborate with the Governor's Highway Safety Office and the Traffic Safety Coalition to implement programs to reduce accidents and death related to drugs, including alcohol, and driving.

Promulgated the rules and regulations for the Certification Of Alcohol Server Training Programs in response to a mandatory alcohol server training law passed in FFY 2004. This process ensures that all training programs are comprehensive and research based. The Department is responsible for reviewing all programs that seek this certification.

3. Through the SIG the Department continues to fund the development of local infrastructure of communities with comprehensive prevention strategies, including environmental ones.

GOAL #2

-An agreement to spend no less than 20 percent on primary prevention programs for individuals who do not require treatment for substance abuse, specifying the activities proposed for each of the six strategies.

FFY 2007
PREVENTION INTENDED USE

The overall goal of the Department of Mental Health, Retardation and Hospitals, Division of Behavioral Healthcare (DBH), the Department, is to prevent and reduce ATOD abuse and related unhealthy behavior through the development of a focused, comprehensive and integrated statewide prevention system.

The primary objective for FFY 2007 is to continue development of an infrastructure to support community-based prevention interventions. The Department will continue the process that will result in the adoption of a statewide framework for prevention, which includes goals, the basic structure and strategies to be used to reach the goals and a description of the roles of various prevention providers in attaining these goals.

In order to achieve this objective, the Department will continue to work closely with CSAP and its technical assistance contractor, the SPF SIG, other State agencies and with community prevention providers.

In FFY 2007, the Department will focus on incorporating the steps of the SPF into planning and developing several key components of a state prevention system including: The Department will also focus on using epidemiological data to guide planning for services, incorporating a coalition-specific module into our management information system, developing enhanced reporting system for Student Assistance Programs, finalization of prevention program standards; and workforce development including certification of prevention professionals. In addition we expect to initiate planning for the development of a prevention technical assistance resource center.

INITIATIVES TO IMPROVE AND ENHANCE THE STATE'S COMPREHENSIVE PREVENTION SYSTEM

1. The Department, under the authority of the Governor's Council on Behavioral Health, will develop a behavioral health strategic plan inclusive of the full IOM spectrum of preventive interventions: prevention, treatment, aftercare/recovery supports. The plan also will incorporate relevant recommendations from previous plans, including the Statewide Substance Abuse Prevention Plan developed through the SIG.

The Youth Development Advisory Committee (YDAC) has served as the advisory body for the SIG and serves as the advisory group for the SPF SIG. The Department will continue to participate in the activities and deliberations of the YDAC.

2. As previously stated 25 awards were made under the State Incentive Grant. The Department will continue to monitor compliance with the objectives of the SIG and provide TA in conjunction with the NE CAPT.

3. Rules and Regulations for the Certification of Prevention Organizations were promulgated in FFY 2006. The Department intends to incorporate the rules and regulations into the contracts of prevention providers in FFY 2007.

4. The Department will continue to work on refinement of the web-based PBPS to track prevention service data and program outcomes including expansion of the existing coalition model.

5. The Department will continue to use the IOM spectrum of preventive intervention, risk and protective factors, and the steps of the Strategic Prevention Framework as its framework for program planning and implementation. We will continue to support the use of evidence-based, culturally appropriate programs, policies, and practices.

6. The Department will continue to collaborate with the University of RI's Community Research and Services Team to examine the current National Outcome Measures of the SAPT Block Grant and the human and material resources the SSA will need to comply with reporting requirements in the future.

INFORMATION MANAGEMENT SYSTEM

The Departments goals for PBPS moving into FFY 2007 include revising the format in which we conduct training classes. We will attempt to incorporate more of the individual users actual planning data into the class thus providing participants the opportunity to complete those modules with real data. We are also considering developing worksheets to help users think about their planning data in terms of compatibility with entering it into PBPS.

The Department will also pilot-test and implement a module specifically tailored to the work of community coalitions. In 2006, the Department began working with KIT solutions to develop a custom coalition module that will include a logic model/program plan, a capacity plan, an evaluation plan, and a report mechanism that is linked to the logic model. We expect a demo of the new module in September of 2006.

NOTE: For more detailed information see RESP034 Planning, 1. Needs Assessment

CAPACITY BUILDING/WORKFORCE DEVELOPMENT

The Department will continue initiatives to enhance the capacity of community providers as well as state prevention staff to improve statewide outcomes via effective planning, use, and evaluation of science-based prevention.

The Department will collaborate with the New England Institute of Addictions Studies, the Center for Substance Abuse Prevention, and the NE CAPT to implement a 7th Annual School of Prevention Studies.

Through a partnership with CSAP's National Center for the Advancement of Prevention, the Department will continue to implement the Rhode Island adaptation of the Pathways to Prevention model, Getting to Prevention Results for science-based planning, evaluation and continuous quality improvement with our providers.

The Department will continue to fund the Drug and Alcohol Treatment Association of RI (DATA), a nationally recognized prevention and treatment training system. (see B.1 Education)

The Department will continue to collaborate with DATA to develop and offer prevention trainings, which will meet ICRC requirements for the certification of prevention professionals.

The Department, working collaboratively with the SPF SIG, will develop the FFY 2007 training and technical plan for RI. In addition, the Department will plan for the initiation of a technical assistance resource center to serve the needs of prevention service providers and staff.

Also, in collaboration with the SPF SIG, and using other, non-SAPT funding, the Department will establish a prevention technical assistance resource center, which will provide "real-time" technical assistance to Safe and Drug Free Schools and Communities and be available to SPF SIG sub-recipients and other prevention services providers, including those funded through the SAPT.

COLLABORATION

Rhode Island's prevention community has long been concerned about collecting reliable municipal-level data and continues to collaborate with other state agencies, and via the recommendations in the SIG Statewide Substance Abuse Prevention Plan, to advocate for an improved youth surveillance system.

The Statewide Substance Abuse Prevention Plan recommends the establishment of a surveillance system that provides data necessary for state and local substance abuse prevention planning. This is a critical policy issue.

"*Establish a coordinated system for the routine collection of youth-focused data that includes collection of local level data relevant to risk or protective factors for substance abuse and which also provides data that are adequate for state agencies to conduct programmatic prevention planning and policy development."*

The state epidemiological workgroup (SEOW) from the SPF SIG was established as a workgroup of the Youth Development Advisory Committee. The SEOW core membership is composed of epidemiologists with an expanded membership to include policy makers and data base managers. The SEOW's primary goal is to deliver data driven community profiles within the RI municipalities. The Department will use the community profiles developed by the SEOW for planning purposes..

The Department will continue to participate in the ad-hoc Student Health Survey Committee with representatives from the Department of Education and Department of Health. This ad-hoc committee was formed to advocate for a centralized, accessible youth surveillance and data collection system meeting the needs of multiple state agencies. This committee will continue to build upon the work of the SPPC and the above referenced recommendation.

The Department will continue to assist the Children's Cabinet by facilitating administrative and technical assistance to the Youth Development Advisory Committee.

Management Coordination between the State Incentive Grant, Strategic Prevention Framework State Incentive Grant, and the Department will continue to include regular meetings between the SIG and SPF SIG Project Managers and the Chief of Prevention and Planning. Specifically this group will focus on joint planning and development of the RI State work plan with the Northeast CAPT and incorporating the SPF into the planning activities of this Department and other state departments with a stake in prevention.

The Department will continue extensive collaboration with the Department of Health on a number of issues, particularly maternal and child health issues, implementation of mechanisms to fulfill the Synar requirements, HIV/TB initiatives, and common legislative issues

The Department will continue to collaborate with the NECAPT, DATA, the Safe and Drug Free Schools Coordinator and SIG coordinator, and other sister state agencies to conduct training and technical assistance initiatives to implement evidence-based programs.

ALLOCATION OF FUNDS

The Department is committed to sustaining a prevention system consisting of culturally appropriate science-based programs and best practices, which are organized into comprehensive community-based prevention on the local level, and are supported by coordinated funding and technical assistance from the state level.

The Department will continue to fund community-based substance abuse prevention programs in response to an RFP issued in March of 2005. This RFP was issued to re-allocate the 20% prevention set-aside to be consistent with the state framework for prevention and CSAP 's guidelines for implementing science-based programs. Programs are within each of the six strategies.

Approximately 70% of the available funding was awarded to applicants that proposed to replicate science-based model programs. Approximately 30% of the available funds were awarded for other programs that have demonstrated success in reducing alcohol, tobacco and other drugs (ATOD) among the target populations.

PREVENTION ACTIVITIES BY STRATEGY CATEGORY

During FFY 2007, the Department will continue to fund activities within each of the six prevention strategy categories under the guiding principle of promoting comprehensive, multi-component prevention interventions.

A. INFORMATION DISSEMINATION

During FFY 2007 ATOD information will be disseminated to approximately 1 million Rhode Islanders, virtually the whole state, from all sectors of the population. This will be achieved through the use of Rhode Island's RADAR Network Center, help lines, media campaigns and public service announcements. Further detail is provided below:

1. In FFY 2007, the Department will continue to fund the statewide substance abuse resource center, In-Rhodes.

    - Who: The targeted population includes State government offices, community prevention, intervention and treatment service providers, schools, community organizations, and the general public.
    - What: In-Rhodes provides the public with timely and innovative educational materials. In-Rhodes is open to the general public and has information and publications for distribution on a variety of substance abuse and other addiction topics. In-Rhodes maintains a library of over 2000 ATOD and AIDS related materials, videos and books; as well as a reference library of over 4,000 documents. Bulk materials are provided to professionals and the general public. In-Rhodes acts as the State RADAR Network Center.
    - When: Ongoing
    - Where: State of Rhode Island
    - How: Direct service provision and formal and informal collaboration with various state and local entities.

2. Help Line/Resource Directory

- Who: The target population is the community at large and those in need of referral services.
- What: The Department will continue to fund the RI Council on Alcoholism and Other Drug Dependence to develop and disseminate the Directory of RI Substance Abuse Treatment and Prevention services and a 24-hour help-line for referral to treatment agencies and support groups.
- When: Ongoing
- Where: State of Rhode Island
- How: Continuing funding contracts to private, non-profit agency.

B. EDUCATION

Drug and Alcohol Treatment Association (DATA) of Rhode Island

- Who: ATOD professionals, human service providers, health care providers, community coalition members.
- What: A core component of the State's prevention and treatment system is the statewide training system. The Department will continue to contract with the Drug and Alcohol Treatment Association of Rhode Island (DATA) to oversee the statewide training system. DATA trains approximately 2000 individuals annually and continues to increase minority representation at training. Training offered by DATA supports the certification of Chemical Dependency Professionals (CDPs), Prevention Specialists, and Student Assistance Counselors. Additional training and workshops will continue to be provided to the statewide network of Rhode Island Substance Abuse Prevention (RISAPA) task forces.

  A key initiative of the Department is the development and support of a trained prevention workforce. The Department will continue to expand training opportunities, especially as these trainings support the certification of prevention and student assistance specialists. In FFY 2007 a priority for the Department in collaboration with DATA will be to develop and offer prevention training, which meet ICRC requirements for the certification of prevention professionals.

  Contracts issued to block grant recipients and the RISAPA task forces include the requirement that the person responsible for prevention program planning and implementation attend training determined by the Department to be relevant to the development of a comprehensive, science-based prevention system.

  To facilitate compliance with block grant requirements, special emphasis continues to be placed on providing AIDS and TB specific training to

substance abuse and mental health prevention, intervention and treatment providers as well as to other human service professionals.

The Department and DATA are represented on the Board of Directors of the New England Institute of Addiction Studies (NEIAS) and assist in the coordination of the training initiatives sponsored by NEIAS. The Department will participate in the planning of the 7th Annual New England School of Prevention Studies and will continue to offer scholarships to NEIAS training. The Department is also represented on the Northeast Center for Advanced Prevention Technology (CAPT).

The Department will continue to promote its training activities through the maintenance of extensive mailing lists and training catalogues.

- When: Ongoing
- Where: State of Rhode Island
- How: Direct service provision, continuation contract with a private non-profit agency, collaboration with community coalitions and professional organizations.

COMMUNITY-BASED PROGRAMS

EACH OF THE FOLLOWING IS A COMMUNITY-BASED EDUCATION PROGRAM

1. Initiatives for Human Development (Education)

   - Who: Low literacy immigrant parents at risk for substance abuse.
   - What: "Parents Are Teachers (PAT)" a CSAP 2001 "promising program" at Progreso Latino in Central Falls. Components of the program include an experiential 13 session parenting curriculum; parent/child sessions using homework for extended practice of skills learned during classroom sessions, a Team Leader program to cultivate past PAT participants as peer helpers. It is proposed to implement a fourth component, training of PAT team leaders to be PAT program facilitators able to implement the program independently.
   - When: Ongoing
   - Where: Central Falls, Rhode Island
   - How: Funding through a competitive RFP process.

2. Comprehensive Community Action, Inc. (Education)

   - Who: Approximately 200 Head Start and Day Care children age 2-5 and their parents.
   - What: "Incredible Years" a Center for Substance Abuse Prevention designated Effective Program The applicant will implement the Incredible Years Training Series including parent skills training and classroom-based child training programs. These program components are designed to promote emotional and

social competence and to prevent aggressive, defiant, oppositional and impulsive behavior in young children 2-7 years old.
- When: Ongoing
- Where: Cranston, Rhode Island
- How: Funding through a competitive RFP process.

3. Child and Family Services of Newport County (Education)

- Who: Approximately 200 sixth grade students at Joseph H. Gaudet Middle School in Middletown, RI.
- What: Life Skills Training (LST) and Strengthening Families Programs (SFP) LST, a three-year comprehensive, interactive prevention program will be offered to all (212) 6th grade students following them through the 8th grade over the course of three years. The program addresses three major components: drug resistance skills, personal self-management, and general social skills. SFP by meeting with a cohort of parents and children provides intensive, interactive and experiential training. The program identifies three major outcome objectives: to improve family relations, increase parenting skills, and increase children's skills.
- When: Academic School Year
- Where: Middletown, Rhode Island
- How: Funding through a competitive RFP process.

4. Providence Housing Authority

- Who: Services will be provided to approximately 130 youth at three PHA owned and operated community centers in Providence.
- What: Three age-appropriate model, promising, and effective programs to address the substance abuse prevention education needs of low income, minority youth and their families living in Providence public housing. The programs to be offered are to children and their parents are "I Can Problem Solve" and "Raising a Thinking Child" as well as an enhancement of the "Life Skills Training" program.
- When: Ongoing
- Where: Providence, Rhode Island
- How: Funding through a competitive RFP process.

EACH OF THE FOLLOWING REPRESENTS A COMPREHENSIVE, MULTI-COMPONENT PREVENTION PROGRAM.

5. Initiatives for Human Development – Teen Institute (Education, Alternatives, Community Process)

- Who: Rhode Island Middle School and High School youth.
- What: Rhode Island Teen Institute (RITI), a comprehensive prevention program targeting positive and negative peer leaders of secondary school age. The primary target is middle school youth. Using a cross-peer model, RITI is designed to maximize the impact of prevention on the youth of Rhode Island by identifying peer leaders in a broad range of community settings, enhancing their leadership skills, reinforcing or fostering their commitment to wellness, and training them to organize their peers to work for prevention in their own community. The proposal seeks to implement 3 residential trainings (2 middle school and 1 high school).
- When: Ongoing
- Where: Rhode Island
- How: Funding through a competitive RFP process.

6. Metropolitan Regional Career & Technical Center (Education, Alternatives, Early Identification and Referral)

   - Who: 50 high-risk 9th and 10th grade students at six small schools in Providence.
   - What: "Leadership & Resiliency" program a Center for Substance Abuse Prevention designated Effective Program. The program will provide group activities designed to promote constructive behaviors, discourage ATOD use, and develop social and physical environments that facilitate drug-free life styles. The program consists of the following components: group meetings; individual and small group sessions, referrals, community service, and outdoor education and leadership development.
   - When: Academic School Year
   - Where: Providence, Rhode Island
   - How: Funding through a competitive RFP process.

7. Pawtucket Substance Abuse Prevention Task Force (Education, Community Process, Early Identification and Referral)

   - Who: Services will be provided to Pawtucket youth and their families.
   - What: Creating Lasting Family Connections (CLFC) a Center for Substance Abuse Prevention designated Effective Program. The program will become part of Project FIRST, which will connect CLFC with the Creating Solutions for Independence (CSI) program at Prospect Heights and Galeco Court in Pawtucket. The implementation of the family-based CLFC will create a comprehensive family based program that will see the expansion of services to include parents and family members of youth currently served by CSI.
   - When: Ongoing
   - Where: Pawtucket, Rhode Island

- How: Funding through a competitive RFP process.

8. Rhode Island Employee Assistance Program, Inc. (RIEAP) (Education, Early Identification and Referral)

   - Who: with 900 students in grades 6-8 at Westerly Middle School.
   - What: "Project Success" a Center for Substance Abuse Prevention designated Effective Program. Program components include Screening and Assessment of students, an 8 session Prevention Education Series, Individual and Group Counseling using motivational interviewing, Referral, Administrative Strategies, and Clinical Strategies.
   - When: Academic School Year
   - Where: Westerly, RI
   - How: Funding through a competitive RFP process.

9. RiverzEdge Arts Project (Education, Alternatives)

   - Who: Services will be provided to 22 educationally and economically disenfranchised Woonsocket area youth 13-19 years old.
   - What: The RiverzEdge Arts Project (RAP) to provide youth with the keys to self-sufficiency through a paid arts apprenticeship that focuses on developing art and business skills, and leadership training, while facilitating improved social skills, work ethics, and team participation. All activities are aimed toward reducing substance abuse behavior and overall at-risk behaviors.
   - When: Ongoing
   - Where: Woonsocket, Rhode Island
   - How: Funding through a competitive RFP process.

10. Socio-Economic Development Center for Southeast Asians (Education, Early Identification and Referral))

    - Who: Services will be provided to approximately 50 at-risk Laotian and Cambodian individuals and their families.
    - What: An intensive substance abuse prevention program for the Laotian and Cambodian communities in Rhode Island. The applicant will provide culturally appropriate and innovative alcohol and other drug abuse and prevention education and assistance that will strengthen the process of helping individuals and families through a culturally appropriate teaching, mentoring, and supportive case management approach.
    - When: Ongoing
    - Where: Providence, Rhode Island
    - How: Funding through a competitive RFP process.

11. Urban League of Rhode Island (Education, Alternatives)

- Who: Services will be provided to teen families that have infant and toddler age children (birth to 24 months).
- What: A developer-designed adaptation of "Dare to Be You" a Center for Substance Abuse Prevention designated Effective Program. The adapted "Dare to Be You" will target teen parents, and work with these teen families that have infant and toddler age children (birth to 24 months). Project objectives include increased self-sufficiency, prevention of repeat pregnancies, reduced use of illicit substances, and improved parenting practices.
- When: Ongoing
- Where: Providence, Rhode Island
- How: Funding through a competitive RFP process.

C. ALTERNATIVES

As a matter of policy, the Department does not fund, through contracts, "free-standing" alternatives programs. The Department prefers to fund comprehensive prevention programs in which healthy alternative activities may be offered in conjunction with other components (usually focused on skill-building). The following are examples of services/activities offered under this strategy (alternatives) as part of a comprehensive prevention program (see detailed descriptions in Section B above).

- Initiatives for Human Development – Teen Institute (See B5)
- Metropolitan Regional Career & Technical Center (See B6)
- Pawtucket Substance Abuse Prevention Task Force (See B7)
- RiverzEdge Arts Project (See B 9)
- Urban League of Rhode Island (See B11)

D. EARLY IDENTIFICATION AND REFERRAL

In FFY 2007 the South County Physicians Initiative (SCPI) and the Student Assistance Program will provide early identification and referral services.

1. South County Physicians Initiative (SCPI)

- Who: Services are provided to youth, ages 12–22, and their parents during well-child visits to pediatric offices. .
- What: A pilot project to determine the steps necessary to implement a standardized substance abuse and mental health screening instrument in pediatric offices, and to facilitate education and referral of identified at risk

youth to appropriate behavioral healthcare providers. The project is conducted by South Kingston Community Prevention Partnership & Narragansett Youth Task Force in five pediatric/primary care offices/centers in South Kingstown and Narragansett.

- When: On-going
- Where: South Kingstown and Narragansett, Rhode Island
- How: Non-competitive contract

2. Rhode Island Student Assistance Program

- Who: Students at 21 senior high schools and 25 middle and junior high schools, and their families. It is estimated that approximately 7,500 students will be served during FY 2007.
- What: The Department focuses its early identification and referral efforts associated with the Block Grant on Student Assistance Programs (SAP) for approximately 26 of the State's senior high schools. Rhode Island follows the Westchester County model for SAP's.

  Three contractors (R.I. Employee Assistance, Codac, and Child & Family Services of Newport County) provide student assistance services within high school and junior high/middle school settings. The student assistance provider agencies place a trained, master's level Student Assistance Counselor in each school 2 ½ to 5 days per week depending on the size of the school. Student Assistance Counselors do assessment and conduct individual and group educational sessions for students determined to be at-risk for alcohol, drug, school, family, peer or other personal problems.
- When: School year
- Where: State of Rhode Island
- How: Non-competitive contracts with three community service providers who have staff qualified to implement the Westchester County Student Assistance Model.

E. COMMUNITY-BASED PROCESS

1. Rhode Island Substance Abuse Prevention Act (RISAPA)-Funded Municipal Task Forces *Task forces are funded through state legislative appropriations totaling over $1 million annually. The following is provided for informational purposes only.*

- Who: 35 substance abuse prevention task forces (community coalitions)
- What: The key community based primary prevention initiative sponsored by the Department continues to support the statewide network of substance abuse prevention task forces.
- When: Ongoing
- Where: State of Rhode Island

- How: Continuation contracts with local municipalities

Established in 1988 by state statute, Rhode Island has a statewide network of community-based substance abuse prevention coalitions, called Task Forces. Task forces have as their primary responsibility the development and implementation of comprehensive prevention plans for their respective communities, which are based on the results of community needs assessments. The Department continues, on an ongoing basis, to monitor the task forces and provide training and technical assistance. Effective with the State Fiscal Year and continuing through the Federal Fiscal Year, the municipal task forces/coalitions are required to develop their annual program plan using the steps of the SPF as a guide.

The task forces are the primary vehicle by which the State implements environmental strategies, not only by the Department, but across State agencies (especially in the areas of tobacco control and violence prevention).

Task forces will continue to work closely with the Enforcing Underage Drinking Laws initiative, particularly focusing their efforts on changing community norms, policies and ordinances.

The Department will continue to conduct monthly meetings for the task forces to afford them a forum to discuss current issues and contract requirements, and to provide them with an ongoing opportunity for networking with their peers.

F. ENVIRONMENTAL

During FFY 2007 the major priority of the Department in the area of environmental strategies will continue to be to reduce youth access to alcohol, and will continue to be funded by non-SAPT dollars. The following is provided for informational purposes only.

1. As the administrative agency for the OJJDP Enforcing the Underage Drinking Laws Program, the Department will conduct semi-annual Alcohol Purchase Surveys to determine compliance with the state statute on alcohol sales to underage persons

2. The Department has promulgated the rules and regulations for the Certification Of Alcohol Server Training Programs. This process ensures that all training programs are comprehensive and research based. The Department will continue to be responsible for reviewing all programs that seek this certification. In addition, the Department will develop procedures for auditing those programs that are currently certified to determine their compliance with the rules and regulations.

3. The EUDL Statewide Advisory committee will continue to meet on a quarterly basis. Additionally, a public education and law enforcement sub-committee will be organized and work on specific issues as identified by the committees.

State:
Rhode Island

Attachment A: Prevention

Answer the following questions about the current year status of policies, procedures, and legislation in your State. Most of the questions are related to Healthy People 2010 objectives. References to these objectives are provided for each application question. To respond, check the appropriate box or enter numbers on the blanks provided. After you have completed your answers, copy the attachment and submit it with your application.

1. Does your State conduct sobriety checkpoints on major and minor thoroughfares on a periodic basis? (HP 26-25)

☐ Yes ☒ No ☐ Unknown

2. Does your State conduct or fund prevention/education activities aimed at preschool children? (HP 26-9)

☒ Yes ☐ No ☐ Unknown

3. Does your State alcohol and drug agency conduct or fund prevention/education activities in every school district aimed at youth grades K-12? (HP 26-9)

SAPT BLOCK GRANT	OTHER STATE FUNDS	DRUG FREE SCHOOLS
☐ Yes	☐ Yes	☐ Yes
☒ No	☒ No	☒ No
☐ Unknown	☐ Unknown	☐ Unknown

4. Does your State have laws making it illegal to consume alcoholic beverages on the campuses of State colleges and universities? (HP 26-11)

☐ Yes ☒ No ☐ Unknown

5. Does your State conduct prevention/education activities aimed at college students that include: (HP 26-11c)

Education Bureau?	☐ Yes	☒ No	☐ Unknown
Dissemination of materials?	☒ Yes	☐ No	☐ Unknown
Media campaigns?	☒ Yes	☐ No	☐ Unknown
Product pricing strategies?	☐ Yes	☒ No	☐ Unknown
Policy to limit access?	☐ Yes	☒ No	☐ Unknown

6. Does your State now have laws that provide for administrative suspension or revocation of drivers' licenses for those determined to have been driving under the influence of intoxicants? (HP 26-24)

☐ Yes ☒ No ☐ Unknown

7. Has the State enacted and enforced new policies in the last year to reduce access to alcoholic beverages by minors such as: (HP 26-11c, 12, 23)

Restrictions at recreational and entertainment events at which youth made up a majority of participants/consumers,

☐ Yes ☒ No ☐ Unknown

New product pricing,

☐ Yes ☒ No ☐ Unknown

New taxes on alcoholic beverages,

☐ Yes ☒ No ☐ Unknown

New Laws or enforcement of penalties and license revocation for sale of alcoholic beverages to minors,

☒ Yes ☐ No ☐ Unknown

Parental responsibility laws for a child's possession and use of alcoholic beverages.

☐ Yes ☒ No ☐ Unknown

8. Does your State provide training and assistance activities for parents regarding alcohol, tobacco, and other drug use by minors?

☒ Yes ☐ No ☐ Unknown

9. What is the average age of first use for the following? (HP 26-9 and 27-4) (if available)

	Age 0 - 5	Age 6 - 11	Age 12 - 14	Age 15 - 18
Cigarettes	☐	☐	☒	☐
Alcohol	☐	☐	☒	☐
Marijuana	☐	☐	☒	☐

10. What is your State's present legal alcohol concentration tolerance level for: (HP 26-25)

Motor vehicle drivers age 21 and older? .08

Motor vehicle drivers under age 21? .02

11. How many communities in your State have comprehensive, community-wide coalitions for alcohol and other durg abuse prevention (HP 26-3)? 39

12. Has your State enacted statutes to restrict promotion of alcoholic beverages and tobacco that are focused principally on young audiences (HP 26-11 and 26-16)?

☐ Yes ☒ No ☐ Unknown

Rhode Island

Goal #3: Pregnant Women Services

GOAL # 3. An agreement to expend not less than an amount equal to the amount expended by the State for FY 1994 to establish new programs or expand the capacity of existing programs to make available treatment services designed for pregnant women and women with dependent children; and, directly or through arrangements with other public or nonprofit entities, to make available prenatal care to women receiving such treatment services, and, while the women are receiving services, child care (See 42 U.S.C. 300x-22(b)(1)(C) and 45 C.F.R. 96.124(c)(e)).

FY 2004 (Compliance):

FY 2006 (Progress):

FY 2007 (Intended Use):

GOAL # 3

-- An agreement to expend not less than an amount equal to the amount expended by the State for FFY 1994 to establish new programs or expand the capacity of existing programs to make available treatment services designed for pregnant women and women with dependent children; and, directly or through arrangements with other public or nonprofit entities, to make available prenatal care to women receiving such treatment services, and, while the women are receiving services, child care (See 42 U.S.C. 300x-22(c)(1)(C) and 45 C.F.R. 96.124(c)(e)).

FFY 2004 (Compliance):

FFY 2006 (Progress):

FFY 2007 (Intended Use):

Utilizing the base number from FFY 1994 of $1,964,739, we have implemented the following services for pregnant women and women with dependent children.

In FFY2004, the state:

see Table IV, Attachment B

- Contracts required all sub-contractors serving pregnant women or women with dependent children to arrange the above referenced services; and
- Contract required that sub-contractors publicize that pregnant women would receive preference in admission for treatment.

In FFY2006, the state:

see Table IV, Attachment B

- The Department continued to fund specialized programs for women, such as Caritas House, a residential program for female adolescents; Providence Center, Pro Cap, Kent County Mental Health, and Tri-Hab substance abuse day treatment for women and their children; Eastman House, a residential substance abuse treatment program for women; SSTARBirth, a long-term residential program for pregnant & postpartum women & children; and specialized methadone funding for women involved in the child welfare system.

- The Department provided additional services to women served by Project Link at Women and Infants' Hospital. Project Link provides clinical services to pregnant/parenting women with co-occurring disorders.

Goal 3, Rhode Island

Department staff worked collaboratively with the Department for Children, Youth and Families to ensure treatment access to women involved in the child welfare system. Department staff attended quarterly meetings of Project Connect continuing collaboration with other state departments and providers to address access to treatment issues for women and families. The Project Connect Coordinating Committee is a collaboration between the Department of Children, Youth and Families (DCYF), substance abuse treatment and other human service professionals that promotes improved outcomes for children and families impacted by substance abuse. The goals of Project Connect are:

- To increase effective collaboration between child and welfare staff, substance abuse treatment providers, family court personnel, and other community service providers.
- To increase access to state-of-the-art information regarding working with substance affected families.
- To advocate for policies and practices which reflect effective services for substance affected families.

To date, the accomplishments of this Committee include:

- Trainings and conferences on best practice for substance affected families involved in the child welfare system.
- Publishing an updated substance abuse treatment provider directory.
- Developing guidelines to promote successful reunifications.
- Advocacy for clients who are substance affected regarding treatment access and the current housing crisis.

Project Connect meets quarterly and includes topic presentations for educational purposes as well as resource sharing. In the past year these topics included:

- Understanding Rite Care benefits for clients and accessing treatment using Neighborhood Health Plan
- Early Intervention Programs
- State-funded detox services
- Patient Advocacy
- Vulnerable Infants Program
- Access to Services

- Contracts for outpatient services require all sub-contractors serving pregnant women or women with dependent children to arrange the above referenced services. Contracts also require that sub-contractors publicize that pregnant women would receive preference in admission for treatment.

- Department staff served on committees with representative of Mothers on Methadone (MOM) program to collaborate on treatment needs of this specialized population.

In FFY2007, the state will:

- continue to work toward enhancing programs serving women;
- continue to fund a number of programs to serve this population; services will include available child care and prenatal care to those women receiving treatment.
- continue to require sub-contractors serving pregnant women or women with dependent children to arrange the above referenced services;
- continue to provide additional services to women served by Project Link at Women and Infants' Hospital. Project Link provides clinical services to pregnant/parenting women with co-occurring disorders;
- continue to require sub-contractors to publicize that pregnant women will receive preference in admission for treatment; and
- continue to meet collaboratively with programs such as Project Connect and MOM to increase effective collaboration between child and welfare staff, substance abuse treatment providers, family court personnel, and other community service providers. To increase access to state-of-the-art information regarding working with substance affected families. Finally, to advocate for policies and practices which reflect effective services for substance affected families.

The Department will continue development of and implementation of aspects of the Rhode Island State Action Plan for an Integrated COD System of Care. Also, the Department will continue development of an integrated behavioral health strategic plan. Both of these processes will explore the needs for expanded services for pregnant women and women with dependent children.

GOAL # 3

-- An agreement to expend not less than an amount equal to the amount expended by the State for FFY 1994 to establish new programs or expand the capacity of existing programs to make available treatment services designed for pregnant women and women with dependent children; and, directly or through arrangements with other public or nonprofit entities, to make available prenatal care to women receiving such treatment services, and, while the women are receiving services, child care (See 42 U.S.C. 300x-22(c)(1)(C) and 45 C.F.R. 96.124(c)(e)).

FFY 2004 (Compliance):

FFY 2006 (Progress):

FFY 2007 (Intended Use):

Utilizing the base number from FFY 1994 of $1,964,739, we have implemented the following services for pregnant women and women with dependent children.

In FFY2004, the state:

see Table IV, Attachment B

- Contracts required all sub-contractors serving pregnant women or women with dependent children to arrange the above referenced services; and
- Contract required that sub-contractors publicize that pregnant women would receive preference in admission for treatment.

In FFY2006, the state:

see Table IV, Attachment B

- The Department continued to fund specialized programs for women, such as Caritas House, a residential program for female adolescents; Providence Center, Pro Cap, Kent County Mental Health, and Tri-Hab substance abuse day treatment for women and their children; Eastman House, a residential substance abuse treatment program for women; SSTARBirth, a long-term residential program for pregnant & postpartum women & children; and specialized methadone funding for women involved in the child welfare system.

- The Department provided additional services to women served by Project Link at Women and Infants' Hospital. Project Link provides clinical services to pregnant/parenting women with co-occurring disorders.

Goal 3, Rhode Island

Department staff worked collaboratively with the Department for Children, Youth and Families to ensure treatment access to women involved in the child welfare system. Department staff attended quarterly meetings of Project Connect continuing collaboration with other state departments and providers to address access to treatment issues for women and families. The Project Connect Coordinating Committee is a collaboration between the Department of Children, Youth and Families (DCYF), substance abuse treatment and other human service professionals that promotes improved outcomes for children and families impacted by substance abuse. The goals of Project Connect are:

- To increase effective collaboration between child and welfare staff, substance abuse treatment providers, family court personnel, and other community service providers.
- To increase access to state-of-the-art information regarding working with substance affected families.
- To advocate for policies and practices which reflect effective services for substance affected families.

To date, the accomplishments of this Committee include:

- Trainings and conferences on best practice for substance affected families involved in the child welfare system.
- Publishing an updated substance abuse treatment provider directory.
- Developing guidelines to promote successful reunifications.
- Advocacy for clients who are substance affected regarding treatment access and the current housing crisis.

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- continue to require sub-contractors to publicize that pregnant women will receive preference in admission for treatment; and
- continue to meet collaboratively with programs such as Project Connect and MOM to increase effective collaboration between child and welfare staff, substance abuse treatment providers, family court personnel, and other community service providers. To increase access to state-of-the-art information regarding working with substance affected families. Finally, to advocate for policies and practices which reflect effective services for substance affected families.

The Department will continue development of and implementation of aspects of the Rhode Island State Action Plan for an Integrated COD System of Care. Also, the Department will continue development of an integrated behavioral health strategic plan. Both of these processes will explore the needs for expanded services for pregnant women and women with dependent children.

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FFY 2007 (Intended Use):

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- To advocate for policies and practices which reflect effective services for substance affected families.

To date, the accomplishments of this Committee include:

- Trainings and conferences on best practice for substance affected families involved in the child welfare system.
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Project Connect meets quarterly and includes topic presentations for educational purposes as well as resource sharing. In the past year these topics included:

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- continue to require sub-contractors to publicize that pregnant women will receive preference in admission for treatment; and
- continue to meet collaboratively with programs such as Project Connect and MOM to increase effective collaboration between child and welfare staff, substance abuse treatment providers, family court personnel, and other community service providers. To increase access to state-of-the-art information regarding working with substance affected families. Finally, to advocate for policies and practices which reflect effective services for substance affected families.

The Department will continue development of and implementation of aspects of the Rhode Island State Action Plan for an Integrated COD System of Care. Also, the Department will continue development of an integrated behavioral health strategic plan. Both of these processes will explore the needs for expanded services for pregnant women and women with dependent children.

Rhode Island

Attachment B: Programs for Women

Attachment B: Programs for Pregnant Women and Women with Dependent Children
(See 42 U.S.C. 300x-22(b); 45 C.F.R. 96.124(c)(3); and 45 C.F.R. 96.122(f)(1)(viii))

For the fiscal year three years prior (FY 2004) to the fiscal year for which the State is applying for funds:

Refer back to your Substance Abuse Entity Inventory (Form 6). Identify those projects serving pregnant women and women with dependent children and the types of services provided in FY 2004. In a narrative of up to two pages, describe these funded projects.

Attachment B: Programs for Pregnant Women and Women with Dependent Children *(See 42 U.S.C. 300x-22(c); 45 C.F.R. 96.124(c)(3); and 45 C.F.R. 96.122(f)(1)(viii))*

For the fiscal year three years prior (FFY 2001) to the fiscal year for which the State is applying for funds:

Refer back to your Substance Abuse Entity Inventory (Form 6). Identify those projects serving pregnant women and women with dependent children and the types of services provided in FFY 2001. In a narrative of ***up to two pages****, describe these funded projects.*

ATTACHMENT B: PROGRAMS FOR WOMEN

FFY2004 - Compliance

The Division of Behavioral Health (DBH) continued to give priority for treatment to pregnant women and women with dependent children, as well as other high-risk female populations. A total of *$2,421,799* in Block Grant and General Revenue funds were targeted at women's treatment services. Following is a description of specialized women's services funded with Block Grant funds.

- **Caritas House - (RI 300028).** 16-bed residential treatment program serving adolescent females. Services include individual, group and family counseling, including sexuality counseling and specialized counseling for girls who have been sexually or physically abused. This population of young women of child-bearing age is considered to be at extremely high risk for becoming pregnant and/or contracting STDs, and was included in the Base for the women's set-aside services at its inception. Also provides for outpatient aftercare (10 slots). Located in Pawtucket (Catchment Area 2), the program serves adolescents from throughout Rhode Island.

  Total Support*: $590,774*

- **Eastman House - (RI 100212).** 12 bed residential program for adult women. Referral to medical/perinatal services provided. Specialized prevention programming for children of women in treatment also provided. Located in Cranston (Catchment Area 4), this program serves women statewide. Clients can be dually enrolled in methadone treatment.

  Total Support: $*283,645*

- **King House (TriHab Residential)- (RI100220).** 12 bed residential program for adult women in Northern RI. Although program cannot physically accommodate children, a wide range of medical/perinatal services are available through relationship with local health center. Located in Woonsocket (Catchment Area 1), provides statewide services. Clients can be dually enrolled in methadone treatment.

  Total Support: $*283,655*

- **The Providence Center (formerly Talbot Treatment Centers) - (RI 100584).** Specialized Day Treatment program for Women and Children (12 slots for women). Provides substance abuse treatment, family counseling, parenting programs, linkages with medical (including perinatal) services, welfare agencies, transportation. Located in Providence (Catchment Area 3), this program is open to women from throughout the state. Clients can be dually enrolled in methadone treatment.

  Total Support: $*202,525*

- **Project Link – Women and Infants' Hospital (RI100949):** Specialized outpatient services for pregnant/parenting women or women of child-bearing age with co-occurring disorders. Clients can be dually enrolled in methadone treatment.

  Total Support: $*105,298*

- **ProCap - (RI100881).** Day treatment for women and children (6 women). Substance abuse counseling, family counseling, day treatment and programming for children, linkages with medical and human services statewide. Nutrition and recreational services also provided. Located in Providence (Catchment Area 3), provides statewide services with a Providence concentration.

  Total Support: $*32,500*

- **Kent County Mental Health Center (now known as Kent Center) - (RI 750115) -** Warwick (Catchment Area 5). Day Treatment Services (5 slots) for women in the central to southern portions of the state. Clients can be dually enrolled in methadone treatment.

  Total support: $*89,500*

- **TriHab Inc. - (RI 100477)** - Central Falls (Catchment Area 2). Day Treatment Services (5 slots) for women in the northern portion of the state. Clients can be dually enrolled in methadone treatment.

  Total support: $*18,200*

- **SSTARBIRTH – (RI100824)** – Cranston (Catchment Area 4). Specialized 12 bed residential program for pregnant/postpartum women and their children. Includes parenting programs, linkages with vocational services, relationship with perinatal services, close relationship with Child Welfare services. Clients can be dually enrolled in methadone treatment.

  Total support: $*103,600*

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Specialized Women's Outpatient Services in Geographic Areas resulting from new Outpatient Contracted implemented in 2004.

Codac: $36,300
Phoenix House: $36,300
Tri-Hab: $36,300

TOTAL SUPPORT - Women-specific: $*1,818,597*

In addition, state funding was used for debt service expenditures on state-owned residential facilities serving women, and Title 19 match funding for the state's 1115 waiver program, Rite Care, totaling $603,202.

TOTAL WOMEN'S SERVICE SUPPORT: *$2,421,799*

To ensure compliance, the state contracts with the above-mentioned agencies to provide women-specific services. Additionally, all contracts for general outpatient and methadone services includes a listing of priority populations, which includes pregnant injecting drug users, pregnant women, and women who are in treatment and working with the Department for Children, Youth and Families toward reunification with their children (e.g., parenting women). All contracts also require that the prime contractor will publicize that pregnant women will receive preference in admission for treatment. All contracts also require that programs serving pregnant or parenting women provide, or arrange for primary medical care, pediatric care, case management and transportation and a variety of specialized interventions for women to ensure appropriate access to treatment and other ancillary services.

Rhode Island is committed to providing comprehensive care to families, and has developed a Medicaid managed care program, RIte Care, which offers both primary and behavioral health care coverage to low-income women and their children. DBH regularly works with consumers and providers in navigating this managed care system, from facilitating enrollment in RIte Care to advocating for appropriate levels and duration of care for pregnant and parenting women and their children. Additionally, DBH regularly meets with allied professionals in social services and primary care to discuss service gaps and attempt to secure funding for additional services, or develop policies to improve care. Representatives from DBH meet quarterly with Project Connect, a collaboration of state departments and providers whose primary focus is to address issues affecting substance abuse treatment for pregnant and/or parenting women. This community participation enables DBH to be aware of emerging issues that affect this population as well as serving in an advisory capacity working toward solutions.

TEDS and MIS data are regularly used to track the capacity and patterns of use of treatment services in Rhode Island. Over the past few years, DBH has begun to collect client data on

pregnant women at the time of admission; however, this data may not reflect women who are unaware of their pregnancy upon admission, do not wish to reveal their pregnancy, or those who may become pregnant while in treatment (but client data may be updated). Information on women with dependent children is not readily available, as the TEDS system captures only "number of persons dependent on income", which is not necessarily related to children. We can examine trends through examining income source - TANF - however, this is not necessarily a complete picture.

Funding was made available to support a specialized program for pregnant and parenting women with co-occurring disorders at Project Link, Women & Infants' Hospital. Women & and Infants Project Link has created better linkages between five existing internal programs that serve pregnant and parenting women, but have not traditionally coordinated services. Staff from the programs meet monthly to facilitate a team approach to serving clients, and to receive cross-training in inter-departmental procedures. With the support of case management, pregnant and parenting women with co-occurring substance abuse and mental health problems can access a care plan that includes medical services, parenting classes, life skills classes, in addition to substance abuse counseling and support for mental health issues.

FFY2006- Progress

During FFY2006, DBH continued to prioritize services for pregnant and parenting women, and allocated Block Grant and State funding for discrete women's services (residential, intensive outpatient, and day treatment), as well as women served in general outpatient and methadone programs. Block Grant and general revenue funds continued to support a variety of services for women in outpatient and methadone maintenance settings, and in Medicaid match (state funding) for RIte Care services.

The Division of Behavioral Healthcare participated in a Women's Health Collaborative with the Department of Health and various community providers to assess current screening tools for women of child bearing age. They reviewed health risk screening tools for this population from other sources nationwide.

DBH has had an active relationship with the MOM (Mothers on Methadone) Program at Kent Hospital. The MOM program has had representation on collaborative committees with DBH focusing on the need to reduce stigma and improve access to treatment services. This program is designed to provide educational and support services specifically to mothers who are on methadone maintenance therapy during pregnancy for the treatment of their opioid dependence and for mothers who are on narcotic medications for long term medical conditions such as chronic pain. The MOM program works to provide a nurturing environment for mother and child while striving to eliminate the myths and stigma sometimes associated with methadone therapy and treatment of chronic pain. Staff, as well as patients is provided with accurate and updated information on opioid dependence and its effects on pregnancy and the newborn.

DBH representatives also continued to participate in Project Connect. Topics addressed in this past year included access to treatment issues, barriers to treatment for pregnant/parenting women, loss of insurance benefits when children are removed from the home, and availability of funded treatment slots. Special presentations were provided by methadone treatment providers and the Vulnerable Infants Program (Project VIP) from Women & Infants Hospital.

Rhode Island has maintained existing contracts for outpatient substance abuse services. These contracts were awarded to five prime contractors who provide services throughout the state. This part of our substance abuse treatment was restructured in 2004 to respond to changing needs in the community for dual diagnosis treatment and to increase access throughout the state to a full continuum of treatment services. DBH staff conducted monitoring reviews of all prime and subcontractors with a focus on contract compliance.

The new general outpatient system for substance abuse treatment in Rhode Island has promoted significant changes in the delivery of care. Programs in different regions have been very creative in designing approaches to address the multiple needs of clients in our system. Each region has responded to the needs of clients in unique ways, which continue to evolve as outcomes and utilization rates are reviewed. DBH meets with prime contractors on a quarterly basis to review reports submitted by the agencies and address any issues in the delivery of care. This collaboration has led to changes in distribution of levels of care within regions based on under/over-utilization. Representatives from each region have met regularly and have forged relationships based on cooperation and support, sharing ideas with each other in a collaborative manner. Aside from database reports, each region will submits quarterly reports to DBH outlining services provided in each category (including women's specific), along with narratives on outreach and case management activities.

One very promising development has been the creation of a "sleep-over partial hospitalization" program available to clients state-wide. This program focuses on clients who meet ASAM PPC-II criteria for a PHP level of care, and who are homeless or have housing situations that are not supportive of recovery. The sleep-over PHP provides a safe living environment for individuals while they address their treatment needs in a less restrictive setting. In the first nine (9) months of fiscal year 2005, this program served 112 Rhode Island residents, well over the prescribed capacity.

What the outpatient system provides for women's treatment is an expansion of access for women to PHP, IOP, and general outpatient levels of care throughout all regions in the state. These contracts have also increased expectations from the state on services provided to pregnant women or women with dependent children to provide or arrange for the following:

- Primary medical care, including referral of women for prenatal care and, while the client is receiving such services, child care;
- Primary pediatric care, including immunization, for their children;

- Gender specific substance abuse treatment and other therapeutic interventions shall address issues of relationships, life skill building, sexual abuse, physical abuse and parenting. While the clients are receiving these services, child care shall b e provided or arranged for;
- Therapeutic interventions for children in custody of women in treatment (shall include developmental needs, issues of sexual and physical abuse/neglect)'
- Case management and transportation to ensure that, women and their children have access to the above mentioned services.

Descriptions and provider IDs for residential, methadone and other services are unchanged from the FY2006 report. These services included:

· **Caritas House**
· **Eastman House**
· **King House**
· **Methadone Treatment for Women Working Toward Reunification**
· **SStarbirth**
· **Project Link-Women & Infants' Hospital**

Day treatment programs (PHP) are incorporated into our general outpatient contracts with prime contractors in five regions. Women can access a full range of outpatient services from PHP to IOP to general outpatient to aftercare services. Each contract specifies a static and dynamic capacity for women's specific treatment. The following are the agencies awarded the prime contract in each region:

- Providence County region: The Providence Center
- Kent County region: The Kent Center
- Northern Rhode Island region: TriHab
- Bristol Newport County region: CODAC Treatment Centers
- Washington County region: Phoenix House

Additionally, Block Grant and General Revenue funds support pregnant and parenting women within outpatient and methadone programs statewide. The state also funds *$302,202* in debt service and $*301,000* in Title 19 match for women's services (total $*603,202*).

FFY2007- Intended Use

Rhode Island will continue to give priority admission to pregnant and parenting women for FFY2007, as evidenced in all contractual agreements with provider agencies. Historically, nearly one-third of all detoxification and treatment admissions has been for women, more than 90% of whom are considered to be at or near child-bearing age. This represents more than 3,500 admissions annually to detoxification and treatment services statewide. Since the inception of the women's set-aside, DBH has continued to expand its planning efforts for women's services

with other allied health and human service agencies who mutually serve women and families affected by substance abuse. This includes the Department for Children, Youth and Families; the Department of Corrections; Department of Health (for both primary health care issues, as well as specialized issues, such as TB, hepatitis, STDs); perinatal centers; and welfare agencies. As service gaps are identified, we continue to work with colleagues in other agencies to locate funding streams or develop policies which improve service quality and access for consumers. These collaborative efforts extend to the development of competitive RFPs to select providers for new services, should new funding become available. It should be noted that representatives of allied agencies regularly serve on DBH's review committees, and DBH likewise participates in reviews sponsored by other state agencies. Decisions about any new or revised initiatives will be made based on continued identification of service gaps, either through collaborative planning, or through data from the Needs Assessment conducted by the North Charles Research and Planning Group. It is expected that DBH will continue to provide or develop women's services in a variety of modalities, in geographically dispersed sites designed to improve access.

The Division of Behavioral Healthcare will continue to collaborate with the Department of Health to develop and refine a health risk screening tool for women of childbearing age. This tool will encompass nutrition, mental health, substance abuse, domestic violence, housing, current stressors, along with physical health. A model of this tool is being used at Women and Infants Hospital and will be distributed to all state hospitals and health clinics.

The outpatient system of care will continue to be monitored through monthly review of CIS data, quarterly reporting forms, and biannual licensing/monitoring reviews. Since beginning this new system, leadership of DBH has been meeting with prime contractors every six months to review changes, progress and any difficulties. We are in the process of incorporating aftercare data into our information systems to track utilization of aftercare systems.

The process of collecting data on women who are pregnant at time of admission and women with dependent children has not been as sufficient as the Department desires. In FFY 2207 the Department will explore ways of improving the sufficiency of this information.

Rhode Island

Attachment B: Programs for Women (contd.)

The PHS Act required the State to expend at least 5 percent of the FY 1993 and FY 1994 block grants to increase (relative to FY 1992 and FY 1993, respectively) the availability of treatment services designed for pregnant women and women with dependent children. In the case of a grant for any subsequent fiscal year, the State will expend for such services for such women not less than an amount equal to the amount expended by the State for fiscal year 1994.

In up to four pages, answer the following questions:

1. Identify the name, location (include sub-State planning area), Inventory of Substance Abuse Treatment Services (I-SATS) ID number (formerly the National Facility Register (NFR) number), level of care (refer to definitions in Section II.4), capacity, and amount of funds made available to each program designed to meet the needs of pregnant women and women with dependent children.

2. What did the State do to ensure compliance with 42 U.S.C. 300x-22(b)(1)(C) in spending FY 2004 block grant and/or State funds?

3. What special methods did the State use to monitor the adequacy of efforts to meet the special needs of pregnant women and women with dependent children?

4. What sources of data did the State use in estimating treatment capacity and utilization by pregnant women and women with dependent children?

5. What did the State do with FY 2004 block grant and/or State funds to establish new programs or expand the capacity of existing programs for pregnant women and women with dependent children?

Attachment B: Programs

The PHS Act required the State to expend at least 5 percent of the FFY 1993 and FFY 1994 block grant to increase (relative to FFY 1992 and FFY 1993 respectively) the availability of treatment services designed for pregnant women and women with dependent children.

In up to four pages, answer the following questions:

1. Identify the name, location (include substate planning area), NFR ID number, type of care (refer to definitions in Section II.5), capacity, and amount of funds made available to each program designed to meet the needs of pregnant women and women with dependent children.

2. What did the State do to ensure compliance with 42 U.S.C. 300x-22(c)(1)(C) in spending FFY 2004 block grant funds?

3. What special methods did the State use to ***monitor*** *the adequacy of efforts to meet the special needs of pregnant women and women with dependent children?*

4. What sources of data did the State use in estimating treatment capacity for and utilization by pregnant women and women with dependent children?

5. What did the State do with FFY 2006 block grant funds to establish new programs or expand the capacity of existing programs for pregnant women and women with dependent children?

1) Programs specific to needs of pregnant women and children with dependent children are described in detail in Response #5.

2) The Division of Behavioral Healthcare conducted annual monitoring reviews of all agencies receiving block grant funds. Contracts with these agencies require submission of an annual financial report, which includes all State of Rhode Island payments, Medicaid reimbursements, and expenditure of funds. The report must be completed by an independent auditing firm.

3) In annual monitoring reviews, the substance abuse unit of the Division of Behavioral Healthcare conducts records and site reviews for all contracted agencies. In conjunction with the licensing unit, the team looks for compliance with specifications outlined in contracts to address the needs of this population. Review of records identifies a program's ability to coordinate prenatal or other healthcare, and linkages with community resources. Review of agency policies provides information on compliance with prioritization of this population, management of any waiting list and publication of

prioritization. DBH meets regularly with advocacy groups, treatment providers, the

4) Department of Corrections, the Department of Health, as well as other sources of referral in an effort to ascertain the adequacy of efforts to provide services to this population. The Department is frequently used by providers and consumers to facilitate referrals and assist in the process of accessing treatment services. Adverse incidents and complaints affecting our population are received by the Substance Abuse Treatment Unit and documented in a centralized database. The unit identifies trends in this system, such as inability for pregnant women to access services. The Department also receives quarterly reports from Project Link that detail services provided, population served, mental health services, client enrollment data, a nursing report and case study.

5) Calculated methods outlined in Response 41 (Women's and Tuberculosis Services Expenditure History) Also, as noted above, the Department utilizes information provided by the treatment and recovery communities. Any complaints regarding inability to access treatment services would be noted in our complaint database.

6) In FFY 2005, the state created a new system for General Outpatient Services. This system has resulted in increased access to a full range of outpatient services statewide. The Division of Behavioral Healthcare worked closely with the prime contractors for each region in FFY2006. Special attention was paid to utilization of various levels of care and changes were made in slot distribution to address the emerging needs of the population. Some areas saw greater use of IOP and others PHP levels of care. DBH identified regional trends and adjusted our expectation for static and dynamic capacity to reflect this data. Ultimately, programs were able to respond to consumer need, including use of day treatment for pregnant and parenting women. Programs were created by prime contractors such as a sleep-over partial hospitalization program. Clients are not limited to regions as catchment areas and are able to utilize creative programming throughout the state. The GOP system has increased collaboration with other service providers, especially mental health providers and primary care physicians. The state also continued to fund partnership grants, improving services to those with co-occurring disorders. Project Link offers specialized services to women with co-occurring disorders and this program is described in greater detail in Response 5.

Rhode Island

Attachment C: Programs for IVDU

Attachment C: Programs for Intravenous Drug Users (IVDUs)
(See 42 U.S.C. 300x-23; 45 C.F.R. 96.126; and 45 C.F.R. 96.122(f)(1)(ix))

For the fiscal year three years prior (FY 2004) to the fiscal year for which the State is applying for funds:

1. How did the State define IVDUs in need of treatment services?

2. What did the State do to ensure compliance with 42 U.S.C. 300x-23 of the PHS Act as such sections existed after October 1, 1992, in spending FY 2004 SAPT Block Grant funds (See 45 C.F.R. 96.126(a))?

3. What did the State do to ensure compliance with 42 U.S.C. 300x-31(a)(1)(F) of the PHS Act prohibiting the distribution of sterile needles for injection of any illegal drug (See 45 C.F.R. 96.135(a)(6))?

4. 42 U.S.C. 300x-23(a)(1) requires that any program receiving amounts from the grant to provide treatment for intravenous drug abuse notify the State when the program has reached 90 percent of its capacity. Describe how the State ensured that this was done. Please provide a list of all such programs that notified the State during FY 2004 and include the program's I-SATS ID number (See 45 C.F.R. 96.126(a)).

5. 42 U.S.C. 300x-23(a)(2)(A)(B) requires that an individual who requests and is in need of treatment for intravenous drug abuse is admitted to a program of such treatment within 14-120 days. Describe how the State ensured that such programs were in compliance with the 14-120 day performance requirement (See 45 C.F.R. 96.126(b)).

6. 42 U.S.C. 300x-23(b) requires any program receiving amounts from the grant to provide treatment for intravenous drug abuse to carry out activities to encourage individuals in need of such treatment to undergo treatment. Describe how the State ensured that outreach activities directed toward IVDUs was accomplished (See 45 C.F.R. 96.126(e)).

Attachment C: Programs for Intravenous Drug users (IVDUs)
(See 42 U.S.C. 300x-23; 45 C.F.R. 96.126; and 45 C.F.R. 96.122(f)(1)(ix))

For the fiscal year three years prior (FFY 2004) to the fiscal year for which the state is applying for funds:

1. How did the State define IVDUs in need of treatment services?

2. What did the State do to ensure compliance with 42 U.S.C. 300x-22(a)(2) and 300x-23 of the PHS Act as such sections existed after October 1, 1992, in spending FFY 1999 SAPT Block Grant funds (See 45 C.F.R. 96.124(a)(2) and 96.126(a))?

3. What did the State do to ensure compliance with 42 U.S.C. 300x-31(a)(1)(F) of the PHS Act prohibiting the distribution of sterile needles for injection of any illegal drug (See 45 C.F.R. 96.135(a)(6))?

4. 42 U.S.C. 300x-23(a)(1) requires that any program receiving amounts from the grant to provide treatment for intravenous drug abuse notify the State when the program has reached 90 percent of its capacity. Describe how the State ensured that this is done. Please provide a list of all such programs that notified the State during FFY 2004 and include the program's NFR ID number (formerly NDATUS) (See 45 C.F.R. 96.126(a)).

5. 42 U.S.C. 300x-23(a)(2)(A)(B) of the PHS Act requires that an individual who requests and is in need of treatment for intravenous drug abuse is admitted to a program of such treatment within 14-120 days? Describe how the State ensured that such programs were in compliance with the 14-120 day performance requirement (See 45 C.F.R. 96.126(b)).

6. 42 U.S.C. 300x-23(b) of the PHS Act required any program receiving amounts from the grant to provide treatment for intravenous drug abuse carry out activities to encourage individuals in need of such treatment to undergo treatment. Describe how the State ensured that outreach activities directed toward IVDU's was accomplished (See 45 C.F.R. 96.126(e)).

ATTACHMENT C: PROGRAMS FOR INTRAVENOUS DRUG USERS

FFY2004 - Compliance

Utilizing the federal definitions in effect in 1991 for targeting IVDUs, the state defined its IVDU initiative to include individuals identified within treatment programs with either primary or secondary drug problems which included intravenous drug use. While a large portion of IVDU set-aside funds were allocated for primary IVDUs in methadone treatment, funding was also allocated to drug-free modalities serving IVDUs throughout the state. Additionally, DBH was committed to training all of its service providers on AIDS related issues, so that HIV infected clients and other high risk populations accessing all modalities could effectively be served either

within treatment programs, or referred to appropriate medical and support services.

To ensure compliance, DBH utilized Block Grant funds to contract with providers to provide the above-mentioned IVDU-specific initiatives, which were provided within both methadone maintenance and drug-free programs that served intravenous drug users. These programs included:

CODAC II (RI 900629) – Providence, CODAC III (RI 301406) – Newport, CODAC IV (RI900975) – East Bay, CODAC 5 *South County*
Methadone Maintenance and Detoxification services - including specialized slots for high-risk populations (HIV-positive, minorities, pregnant women). In addition to direct treatment services, CODAC also provides onsite pre- and post-testing counseling, testing, coordination with primary care physicians, assistance with accessing clinical trial programs and a wide range of supportive services related to HIV. Serve clients statewide.

Block Grant Support: $666,590

Methadone - DCYF Reunification Services (varied providers)
Fee for Service methadone maintenance and related HIV services for parenting women in treatment working with DCYF toward reunification with their children.

Block Grant Support: $358

SSTAR DETOX

Block Grant support: $749,580
Total IVDU Block Grant support: $1,416,528

All contracts with providers who receive federal Block Grant funds include the stipulation that funds may not be used to "carry out any program of distributing sterile needles for the hypodermic injection of any illegal drug or distributing bleach for the purpose of cleaning needles for such injections, or, to carry out (AIDS) testing unless such testing is accompanied by appropriate pre-test counseling and appropriate post-test counseling."

Contract language for providers who received federal Block Grant funds and who served IVDUs included the requirement that they were to notify DBH upon reaching 90% of their capacity to admit individuals to the program. Additionally, contract monitors review capacity as part of their annual review process (as well as monitoring utilization on an ad hoc basis through examination of active clients within the MIS system). Programs (including the State 800#/Helpline) and/or individual clients routinely contact DBH, which brokers admissions to service in emergencies for assistance in accessing treatment. Due to lack of funding and personnel, we have been unable to establish an effective and efficient waiting list management program.

All contracts with programs funded by Block Grant funds included language requiring that providers make every attempt to admit individuals within 14 days after making the request for admission, or 120 days after the request if interim services are provided. The contract further defines what interim services are to be provided. Monitors review this activity as part of their annual review process. Additionally, DBH staff routinely assists consumers and their family members in accessing services in emergency situations.

The State has a single contractor for statewide detoxification services. The contractspecifies that detoxification services must be provided on demand. For contract monitoring purposes, this means that a client must be admitted within 48 hours of requesting service.

All contracts with programs funded by Block Grant funds included language requiring that they conduct outreach activities to intercede specifically with IVDUs, in order to provide HIV counseling, and refer individuals to treatment, or medical/other support. Although not funded by DBH, the Department of Health (DOH) and their community programs provide a wide range of street outreach activities to intravenous drug users designed to reduce harm and refer IVDUs to treatment DBH and DOH regularly collaborate. DBH staff regularly attends DOH committee meetings targeting the injection drug user population, specifically, the IVDU Task Force and the Rhode Island Community Planning Group for HIV Prevention. State and federal funds were reallocated across the state to improve access to services. This action was a response to the "Rhode Island Methadone Treatment Report", provided by Health and Addiction Research Inc. and funded by CSAT technical assistance initiative.

FFY2006- Progress

Continued to provide services at methadone clinics provided by CODAC II, III, IV, and 5, as well as funding all methadone programs through the reunification program with DCYF. Also continued to provide services in drug-free and medical detoxification settings for individuals who use illicit drugs intravenously or engage in risky behavior.

DBH staff continued to meet with clinical managers of opioid treatment programs to discuss patient care issues and to improve the quality of Opiate Treatment Services. DBH staff continued to attend the monthly Opioid Treatment Program (OTP) provider meeting. This is an opportunity to address clinical service issues as well as offer technical assistance. DBH staff continued to assist in the preparation of OTPs to meet CSAT regulations regarding accreditation. To date, all opioid treatment programs have had positive accreditation outcomes.

The DBH staff and Department of Health (DOH) staff continued to work collaboratively on a Cross training initiative through the Drug and Alcohol Treatment Association of RI (DATA). This initiative addressed substance abuse and infectious disease issues. The primary purpose of the initiative was the prevention and care of behavioral healthcare issues and infectious diseases, and was based on the curriculum developed by the Substance Abuse and Mental Health

Administration (SAMHSA) and the Center for Disease Control and Prevention (CDC). Trainings have been offered in October/November 2005. They were well attended. The evaluations have been very good.

Several workgoups, in collaboration with DOH, were developed to address the needs of injection drug users. They are the HIV Provision of Care workgroup, the Injection Drug User Task Force, the Viral Hepatitis Advisory Group, and the Methamphetamine Task Force. These workgroups consist of DBH staff, DOH staff, substance abuse treatment providers, other community organizations and consumers. One of our goals is to improve outreach activities to better engage injection drug users into treatment. One of our providers has successfully secured funding from CDC, CSAT, and the Rhode Island Department of Health to reach this population
Recent provider collaborations have occurred to address the increasing concern for adolescent opioid abuse. Discovery House, a methadone treatment provider, has joined forces with Caritas House, a provider of inpatient and outpatient adolescent treatment services, to offer a unique program combining outpatient methadone withdrawal with adolescent intensive outpatient services.

FFY2007 - Intended

DBH will continue to provide specialized services for IVDUs in both narcotic treatment (methadone) and drug-free programs throughout Rhode Island. The "Rhode Island Methadone Treatment Report" indicates that patients in our opioid treatment agencies have access to HIV/AIDS and TB services. Recommendations included improving education regarding risk factors regarding Viral Hepatitis. CODAC treatment centers have been and will continue to offer HepB vaccines for all appropriate patients in their opioid treatment programs. The Rhode Island Department of Health has secured funding for HepB vaccines to be offered in two sites.

DBH will continue to encourage substance abuse providers to attend training for substance abuse and infectious disease issues at DATA and funded by the Department of Health through the Project Reach program. These trainings are funded by the Department of Health through the Project Reach program.

DBH will continue to collaborate with the DOH on workgroups to improve outreach activities to better engage injection drug users into treatment.

Rhode Island

Attachment D: Program Compliance Monitoring

Attachment D: Program Compliance Monitoring
(See 45 C.F.R. 96.122(f)(3)(vii))

The Interim Final Rule (45 C.F.R. Part 96) requires effective strategies for monitoring programs' compliance with the following sections of the PHS Act: 42 U.S.C. 300x-23(a); 42 U.S.C. 300x-24(a); and 42 U.S.C. 300x-27(b).

For the fiscal year two years prior (FY 2005) to the fiscal year for which the State is applying for funds:

In up to three pages provide the following:

- A description of the strategies developed by the State for monitoring compliance with each of the sections identified below:

1. Notification of Reaching Capacity 42 U.S.C. 300x-23(a) (See 45 C.F.R. 96.126(f) and 45 C.F.R. 96.122(f)(3)(vii));

2. Tuberculosis Services 42 U.S.C. 300x-24(a) (See 45 C.F.R. 96.127(b) and 45 C.F.R. 96.122(f)(3)(viii)); and

3. Treatment Services for Pregnant Women 42 U.S.C. 300x-27(b) (See 45 C.F.R. 96.131(f) and 45 C.F.R. 96.122(f)(3)(vii)).

- A description of the problems identified and corrective actions taken.

Attachment D: Program Compliance Monitoring *(See 45 C.F.R. 96.122(f)(3)(vii))*

The Interim Final Rule (45 C.F.R. Part 96) requires effective strategies for monitoring programs' compliance with the following sections of the PHS Act: 42 U.S.C. 300x-23(a); 42 U.S.C. 300x-
24(a); and 42 U.S.C. 300x-27(b).

For the fiscal year two years prior (FFY 2002) to the fiscal year for which the state is applying for funds:

In ***up to three pages*** *provide the following:*

__ *A description of the strategies developed by the State for monitoring compliance with each of the sections identified below:*

1. ***Notification of Reaching Capacity*** *42 U.S.C. 300x-23(a) (See 45 C.F.R. 96.126(f) and 45 C.F.R. 96.122(f)(3)(vii));*

2. ***Tuberculosis Services*** *42 U.S.C. 300x-24(a) (See 45 C.F.R. 96.127(b) and 45 C.F.R. 96.122(f)(3)(viii)); and*

3. ***Treatment Services for Pregnant Women*** *42 U.S.C. 300x-27(b) (See 45 C.F.R. 96.131(f) and 45 C.F.R. 96.122(f)(3)(vii)).*

__ *A description of the problems identified and corrective actions taken.*

Attachment D: Compliance Monitoring

Notification of Reaching Capacity

The Rhode Island Department of Mental Health, Retardation and Hospitals - Division of Behavioral Health (DBH) notification of reaching capacity includes:

compiling program utilization data in DSA's Client Information System (CIS). The CIS captures active client caseloads in all contract programs. The CIS requires treatment programs to submit admission and discharge data using a unique client identifier on a defined
schedule:

- real time for detoxification services,
- **daily** for Narcotic Treatment Programs,
- monthly for outpatient programs, and
- monthly for residential programs

While the CIS is not currently configured to collect and process data for Capacity and Waiting List Management Systems requirements in an automated manner, the currency of the information and the continuous comparison of each program's current utilization versus capacity provides DBH the means to pro-actively address service issues. Also, capacity is almost always an issue in residential settings where the maximum number of beds is established two ways: one by license and secondly by the facility physical capacity. Capacity is almost never an issue in outpatient settings because there is no capacity established in licensing and physical capacity can be addressed operationally, e.g. through scheduling clinical appointments. Thus the primary area at issue is the residential program settings.

Through contract, providers are required to contact the Department when they reach 90 percent capacity. The prime contractors under the GOP have been instructed to notify the Department whenever the wait for service exceeds 21 calendar days.

Tuberculosis Services

All methadone, residential, and medical detoxification treatment programs are required by licensing regulations to provide a pre-admission physical, which includes necessary laboratory work to include tuberculosis (PPD-Mantoux) testing. In addition, the contracts with treatment programs specify that the program must routinely make available tuberculosis services directly or through arrangements with other entities to all individuals receiving treatment for substance abuse.

Department staff routinely assesses compliance with Federal regulations and state contract and licensing requirements during compliance site visits.

Treatment Services for Pregnant Women

In Rhode Island, all pregnant women under 250 percent of the Federal Poverty Level are covered under the RIte Care Program, the State s approved 1115 Medicaid waiver program. RIte Care covers all primary health care and substance abuse treatment services. Under RIte Care, the Managed Care Operator is able to contract with any provider for the provision of required substance abuse treatment services. As such, services may be provided outside the publicly funded system. The Rhode Island Department of Human Services (DHS), the agency which administers the RIte Care Program, continuously monitors access and utilization of services, and through these processes, is able to insure access to necessary and clinically appropriate services.

Through these continuous and active processes, the DBH and in the case of DHS for substance abuse treatment services for pregnant women, the State of RI has positioned itself to insure access to services and address the requirements under 45 C. F. R. 96.126(c) for intravenous drug services and 45 C. F. R. 96.131(c) for services for pregnant women.

As mentioned in previous sections, the Department routinely assesses compliance with Federal regulations and state contract and licensing requirements as an integral part of its monitoring and compliance site visits.

Rhode Island

Goal #4: IVDU Services

GOAL # 4. An agreement to provide treatment to intravenous drug abusers that fulfills the 90 percent capacity reporting, 14-120 day performance requirement, interim services, outreach activities and monitoring requirements (See 42 U.S.C. 300x-23 and 45 C.F.R. 96.126).

FY 2004 (Compliance):

FY 2006 (Progress):

FY 2007 (Intended Use):

GOAL # 4

-- An agreement to provide treatment to intravenous drug abusers that fulfills the 90 percent capacity reporting, 14-120 day performance requirement, interim services, outreach activities and monitoring requirements (See 42 U.S.C. 300x-23 and 45 C.F.R. 96.126).

FFY 2004 (Compliance):

FFY 2006 (Progress):

FFY 2007 (Intended Use):

GOAL # 4. An agreement to provide treatment to intravenous drug abusers that fulfills the 90 percent capacity reporting, 14-20 day performance requirement, interim services, outreach activities and monitoring requirements.

In FFY2004, the state:

- continued activity in Attachment C
- continued activity in Attachment G
- Required contracted programs that treat individuals for intravenous drug use provide the above referenced services.
- continued collaboration with the Department of Health's ENCORprogram (Education, Needle Exchange, Counseling, Outreach and Referral) which is an HIV (and other Blood-borne pathogens) prevention/intervention aimed at injecting drug users (note: no Block Grant dollars were used for needle exchange activity)

In FFY2006, the state:

- Continues activity in Attachment C
- Continues activity in Attachment G
- Requires contracted programs that treat individuals for intravenous drug use provide the above referenced services.
- Continues collaboration with the Department of Health's ENCORprogram (Education, Needle Exchange, Counseling, Outreach and Referral) which is an HIV (and other Blood-borne pathogens) prevention/intervention aimed at injecting drug users (note: no Block Grant dollars were used for needle exchange activity)

In FFY2007, the state will:

- Continue activity in Attachment C

- Continue activity in Attachment G
- Require contracted programs that treat individuals for intravenous drug use provide the above referenced services.
- Continue collaboration with the Department of Health's ENCORprogram (Education, Needle Exchange, Counseling, Outreach and Referral) which is an HIV (and other Blood-borne pathogens) prevention/intervention aimed at injecting drug users (note: no Block Grant dollars were used for needle exchange activity)

ATTACHMENT C: PROGRAMS FOR INTRAVENOUS DRUG USERS

FFY2004 - Compliance

Utilizing the federal definitions in effect in 1991 for targeting IVDUs, the state defined its IVDU initiative to include individuals identified within treatment programs with either primary or secondary drug problems which included intravenous drug use. While a large portion of IVDU set-aside funds were allocated for primary IVDUs in methadone treatment, funding was also allocated to drug-free modalities serving IVDUs throughout the state. Additionally, DBH was committed to training all of its service providers on AIDS related issues, so that HIV infected clients and other high risk populations accessing all modalities could effectively be served either within treatment programs, or referred to appropriate medical and support services.

To ensure compliance, DBH utilized Block Grant funds to contract with providers to provide the above-mentioned IVDU-specific initiatives, which were provided within both methadone maintenance and drug-free programs that served intravenous drug users. These programs included:

CODAC II (RI 900629) – Providence, CODAC III (RI 301406) – Newport, CODAC IV (RI900975) – East Bay, CODAC 5 *South County*
Methadone Maintenance and Detoxification services - including specialized slots for high-risk populations (HIV-positive, minorities, pregnant women). In addition to direct treatment services, CODAC also provides onsite pre- and post-testing counseling, testing, coordination with primary care physicians, assistance with accessing clinical trial programs and a wide range of supportive services related to HIV. Serve clients statewide.

Block Grant Support: $666,590

Methadone - DCYF Reunification Services (varied providers)
Fee for Service methadone maintenance and related HIV services for parenting women in treatment working with DCYF toward reunification with their children.

Block Grant Support: $358

SSTAR DETOX

Block Grant support: $749,580
Total IVDU Block Grant support: $1,416,528

All contracts with providers who receive federal Block Grant funds include the stipulation that funds may not be used to "carry out any program of distributing sterile needles for the hypodermic injection of any illegal drug or distributing bleach for the purpose of cleaning needles for such injections, or, to carry out (AIDS) testing unless such testing is accompanied by appropriate pre-test counseling and appropriate post-test counseling."

Contract language for providers who received federal Block Grant funds and who served IVDUs included the requirement that they were to notify DBH upon reaching 90% of their capacity to admit individuals to the program. Additionally, contract monitors review capacity as part of their annual review process (as well as monitoring utilization on an ad hoc basis through examination of active clients within the MIS system). Programs (including the State 800#/Helpline) and/or individual clients routinely contact DBH, which brokers admissions to service in emergencies for assistance in accessing treatment. Due to lack of funding and personnel, we have been unable to establish an effective and efficient waiting list management program.

All contracts with programs funded by Block Grant funds included language requiring that providers make every attempt to admit individuals within 14 days after making the request for admission, or 120 days after the request if interim services are provided. The contract further defines what interim services are to be provided. Monitors review this activity as part of their annual review process. Additionally, DBH staff routinely assists consumers and their family members in accessing services in emergency situations.

The State has a single contractor for statewide detoxification services. The contractspecifies that detoxification services must be provided on demand. For contract monitoring purposes, this means that a client must be admitted within 48 hours of requesting service.

All contracts with programs funded by Block Grant funds included language requiring that they conduct outreach activities to intercede specifically with IVDUs, in order to provide HIV counseling, and refer individuals to treatment, or medical/other support. Although not funded by DBH, the Department of Health (DOH) and their community programs provide a wide range of street outreach activities to intravenous drug users designed to reduce harm and refer IVDUs to treatment DBH and DOH regularly collaborate. DBH staff regularly attends DOH committee meetings targeting the injection drug user population, specifically, the IVDU Task Force and the Rhode Island Community Planning Group for HIV Prevention. State and federal funds were reallocated across the state to improve access to services. This action was a response to the

"Rhode Island Methadone Treatment Report", provided by Health and Addiction Research Inc. and funded by CSAT technical assistance initiative.

FFY2006- Progress

Continued to provide services at methadone clinics provided by CODAC II, III, IV, and 5, as well as funding all methadone programs through the reunification program with DCYF. Also continued to provide services in drug-free and medical detoxification settings for individuals who use illicit drugs intravenously or engage in risky behavior.

DBH staff continued to meet with clinical managers of opioid treatment programs to discuss patient care issues and to improve the quality of Opiate Treatment Services. DBH staff continued to attend the monthly Opioid Treatment Program (OTP) provider meeting. This is an opportunity to address clinical service issues as well as offer technical assistance. DBH staff continued to assist in the preparation of OTPs to meet CSAT regulations regarding accreditation. To date, all opioid treatment programs have had positive accreditation outcomes.

The DBH staff and Department of Health (DOH) staff continued to work collaboratively on a Cross training initiative through the Drug and Alcohol Treatment Association of RI (DATA). This initiative addressed substance abuse and infectious disease issues. The primary purpose of the initiative was the prevention and care of behavioral healthcare issues and infectious diseases, and was based on the curriculum developed by the Substance Abuse and Mental Health Administration (SAMHSA) and the Center for Disease Control and Prevention (CDC). Trainings have been offered in October/November 2005. They were well attended. The evaluations have been very good.

Several workgoups, in collaboration with DOH, were developed to address the needs of injection drug users. They are the HIV Provision of Care workgroup, the Injection Drug User Task Force, the Viral Hepatitis Advisory Group, and the Methamphetamine Task Force. These workgroups consist of DBH staff, DOH staff, substance abuse treatment providers, other community organizations and consumers. One of our goals is to improve outreach activities to better engage injection drug users into treatment. One of our providers has successfully secured funding from CDC, CSAT, and the Rhode Island Department of Health to reach this population
Recent provider collaborations have occurred to address the increasing concern for adolescent opioid abuse. Discovery House, a methadone treatment provider, has joined forces with Caritas House, a provider of inpatient and outpatient adolescent treatment services, to offer a unique program combining outpatient methadone withdrawal with adolescent intensive outpatient services.

DBH continued to provide interim services involving individualized based assessment of need and symptom severity are provided for Rhode Island residents awaiting substance abuse

treatment services. Self-pay options exist for people awaiting state-funded treatment at any of our outpatient providers, including methadone maintenance treatment; outpatient capacity is not as finite as it is in residential treatment. Some regions have developed orientation groups as interim services for individuals awaiting admission. These groups provide clients with clear expectations of the treatment experience and provide for crisis intervention. The state-contracted detoxification provider has used sleepover partial hospitalization beds as interim care for clients awaiting admission into residential treatment. Individuals are stepped-down to this level of care if the discharge plan calls for residential treatment and the bed is not immediately available, but will be shortly. When the wait for residential treatment may be longer, the detox contractor, along with other referring agents, may refer clients to the transitional beds available at our contracted long-term care facility. These beds, housed at The Providence Center's long-term care residential program are designated specifically for that purpose.

FFY2007 - Intended

DBH will continue to provide specialized services for IVDUs in both narcotic treatment (methadone) and drug-free programs throughout Rhode Island. The "Rhode Island Methadone Treatment Report" indicates that patients in our opioid treatment agencies have access to HIV/AIDS and TB services. Recommendations included improving education regarding risk factors regarding Viral Hepatitis. CODAC treatment centers have been and will continue to offer HepB vaccines for all appropriate patients in their opioid treatment programs. The Rhode Island Department of Health has secured funding for HepB vaccines to be offered in two sites.

DBH will continue to encourage substance abuse providers to attend training for substance abuse and infectious disease issues at DATA and funded by the Department of Health through the Project Reach program. These trainings are funded by the Department of Health through the Project Reach program.

DBH will continue to collaborate with the DOH on workgroups to improve outreach activities to better engage injection drug users into treatment.

DBH will continue to provide interim services involving individualized based assessment of need and symptom severity are provided for Rhode Island residents awaiting substance abuse treatment services. Self-pay options exist for people awaiting state-funded treatment at any of our outpatient providers, including methadone maintenance treatment; outpatient capacity is not as finite as it is in residential treatment. Some regions have developed orientation groups as interim services for individuals awaiting admission. These groups provide clients with clear expectations of the treatment experience and provide for crisis intervention. The state-contracted detoxification provider has used sleepover partial hospitalization beds as interim care for clients awaiting admission into residential treatment. Individuals are stepped-down to this level of care if the discharge plan calls for residential treatment and the bed is not immediately available, but

will be shortly. When the wait for residential treatment may be longer, the detox contractor, along with other referring agents, may refer clients to the transitional beds available at our contracted long-term care facility. These beds, housed at The Providence Center's long-term care residential program are designated specifically for that purpose.

Attachment G: Capacity Management & Waiting List Systems

The Rhode Island Department of Mental Health, Retardation and Hospitals - Division of Behavioral Healthcare Services has undertaken the following steps regarding Capacity Management and Waiting List Systems:

- maintaining and ongoing monitoring of utilization data in DBH's Client InformationSystem (CIS). The CIS collects active client caseload information from all contract programs using a unique client identifier - three initials and last four digits of social security - for all admissions and discharges. DBH has implemented a revised, accelerated schedule on submitting utilization data. The schedule which follows, has enhanced our oversight of utilization system-wide and by program by assuring that the data is current:

    - real time for detoxification services,
    - **daily** for Narcotic Treatment Programs,
    - monthly for outpatient programs, and
    - monthly for residential programs

While the CIS is not currently specifically set-up to collect and process data to meet Capacity and Waiting List Management Systems needs in an automated manner, the currency of the information and the continuous comparison of each programs current utilization versus capacity provides DBH the means to pro-actively address service issues. Also, capacity is almost always an issue in residential settings where the maximum number of beds is established two ways: one by license and secondly by the facility=s physical capacity. Capacity is almost never an issue in outpatient settings because there is no capacity established in licensing and physical capacity can be addressed operationally, e.g. through scheduling/staggering clinical appointments. Thus the primary area at issue is the residential program settings.

The State has a single contractor for statewide detoxification services. The contract, a global capitated at-risk, specifies that detoxification services must be provided on demand. For contract monitoring purposes, this means that a client must be admitted within 48 hours of requesting service.

The DBH functions as the central registry for all methadone programs licensed in the State. Through this activity, DBH is in almost daily contact with narcotic treatment programs. As a component of this clearing process, the methadone programs must be contact with each other. This further insures that clients requesting admission into an IVDU program is handled in the most expeditious manner.

Contract language, which specifies admission preference - in addition to the Block Grant priority populations requirements, specifies other additional populations and financial eligibility, which insures the most needy are served. The contract also requires the provision of interim services when the program reaches capacity and cannot be admitted, and the maintenance of a waiting list, identifying each client by the unique client identifier.

By conducting onsite Program Monitoring and regular meetings with drug-free treatment programs, the DBH has continuous information on the relationship of capacity to demand in each program. Through the regular meetings, DBH is able to prospectively ascertain when programs are approaching 90.0 percent of capacity. Also, during the onsite monitoring visit the review ascertains whether the program complied with contract requirements identified above.

As only residential programs generally have a defined finite capacity, the inability to admit clients requesting treatment are limited to this service category, and DBH maintains ongoing communications and oversight of utilization through the CIS and contacts with the agencies. Pregnant women may be placed on a waiting list for Sstarbirth, our contract residential treatment provider for pregnant and post-partum women. Upon assessment, women are referred to other residential treatment programs for interim services and are prioritized for admission. All levels of outpatient treatment may be utilized as interim services for women who are awaiting placement at Sstarbirth.

Contract language for the new GOP system specifies that if the Provider's static capacity is over subscribed, a wait list for services may be established. However, before a client is wait listed for a service, the Provider will determine if there exists capacity at another Department Provider in a region the client could travel to. Static and dynamic capacity is reviewed on a monthly basis for the each of the GOP prime contractors. Prime Contractors are also required to complete quarterly reports to the Department of MHRH, Division of Behavioral Healthcare outlining the number of weekly assessments, admissions, discharges and census data along with frequency of clinical services.

In Rhode Island, for all practical purposes all pregnant women are covered for substance abuse services outside of the publicly funded substance abuse system. Specifically, while the income limit for indigent services is 200 percent of the Federal Poverty Level, other public and private initiatives cover pregnant women in effect provide universal coverage:

- pregnant and women with children with income under 250 percent of the Federal Poverty Level are covered under the RIte Care Program, this State=s approved 1115 Medicaid waiver program. Under RIte Care all substance abuse treatment services are in-plan.

- pregnant women in households between 251 and 350 percent of the Federal Poverty Level are eligible for RIte Care Program during the period of the pregnancy. Under this situation,

the women are eligible for the same array of services as the first group, to include a full range of substance abuse treatment services.

Under RIte Care, the Managed Care Operator is able to contract with any provider for the provision of required substance abuse treatment services. As such, services may be provided in programs not part of the publicly funded system. The Rhode Island Department of Human Services (DHS), the agency which administers the RIte Care Program, continuously monitors access and utilization of services, and through these processes, is able to insure access to necessary and clinically appropriate services.

Although pregnant women are receiving required substance abuse treatment services under other auspices, when conducting on-site monitoring, DBH's monitors confirm the preferential admission policy, and the treatment agency's policy(ies) and practices on maintaining contact and providing interim services to applicants awaiting admission into treatment. Further, through a review of case records, DBH is able to affirm that these requirements are fully met.

Through these continuous and active processes, the DBH and in the case of DHS for substance abuse treatment services for pregnant women, the State of RI has implemented steps to address interim services needs and services to pregnant women as prescribed under 45 C. F. R. 96.126(c) for intravenous drug services and 45 C. F. R. 96.131(c) for services for pregnant women.

GOAL # 4

-- An agreement to provide treatment to intravenous drug abusers that fulfills the 90 percent capacity reporting, 14-120 day performance requirement, interim services, outreach activities and monitoring requirements (See 42 U.S.C. 300x-23 and 45 C.F.R. 96.126).

FFY 2004 (Compliance):

FFY 2006 (Progress):

FFY 2007 (Intended Use):

GOAL # 4. An agreement to provide treatment to intravenous drug abusers that fulfills the 90 percent capacity reporting, 14-20 day performance requirement, interim services, outreach activities and monitoring requirements.

In FFY2004, the state:

- continued activity in Attachment C
- continued activity in Attachment G
- Required contracted programs that treat individuals for intravenous drug use provide the above referenced services.
- continued collaboration with the Department of Health's ENCORprogram (Education, Needle Exchange, Counseling, Outreach and Referral) which is an HIV (and other Blood-borne pathogens) prevention/intervention aimed at injecting drug users (note: no Block Grant dollars were used for needle exchange activity)

In FFY2006, the state:

- Continues activity in Attachment C
- Continues activity in Attachment G
- Requires contracted programs that treat individuals for intravenous drug use provide the above referenced services.
- Continues collaboration with the Department of Health's ENCORprogram (Education, Needle Exchange, Counseling, Outreach and Referral) which is an HIV (and other Blood-borne pathogens) prevention/intervention aimed at injecting drug users (note: no Block Grant dollars were used for needle exchange activity)

In FFY2007, the state will:

- Continue activity in Attachment C

- Continue activity in Attachment G
- Require contracted programs that treat individuals for intravenous drug use provide the above referenced services.
- Continue collaboration with the Department of Health's ENCORprogram (Education, Needle Exchange, Counseling, Outreach and Referral) which is an HIV (and other Blood-borne pathogens) prevention/intervention aimed at injecting drug users (note: no Block Grant dollars were used for needle exchange activity)

ATTACHMENT C: PROGRAMS FOR INTRAVENOUS DRUG USERS

FFY2004 - Compliance

Utilizing the federal definitions in effect in 1991 for targeting IVDUs, the state defined its IVDU initiative to include individuals identified within treatment programs with either primary or secondary drug problems which included intravenous drug use. While a large portion of IVDU set-aside funds were allocated for primary IVDUs in methadone treatment, funding was also allocated to drug-free modalities serving IVDUs throughout the state. Additionally, DBH was committed to training all of its service providers on AIDS related issues, so that HIV infected clients and other high risk populations accessing all modalities could effectively be served either within treatment programs, or referred to appropriate medical and support services.

To ensure compliance, DBH utilized Block Grant funds to contract with providers to provide the above-mentioned IVDU-specific initiatives, which were provided within both methadone maintenance and drug-free programs that served intravenous drug users. These programs included:

CODAC II (RI 900629) – Providence, CODAC III (RI 301406) – Newport, CODAC IV (RI900975) – East Bay, CODAC 5 *South County*
Methadone Maintenance and Detoxification services - including specialized slots for high-risk populations (HIV-positive, minorities, pregnant women). In addition to direct treatment services, CODAC also provides onsite pre- and post-testing counseling, testing, coordination with primary care physicians, assistance with accessing clinical trial programs and a wide range of supportive services related to HIV. Serve clients statewide.

Block Grant Support: $666,590

Methadone - DCYF Reunification Services (varied providers)
Fee for Service methadone maintenance and related HIV services for parenting women in treatment working with DCYF toward reunification with their children.

Block Grant Support: $358

SSTAR DETOX

Block Grant support: $749,580
Total IVDU Block Grant support: $1,416,528

All contracts with providers who receive federal Block Grant funds include the stipulation that funds may not be used to "carry out any program of distributing sterile needles for the hypodermic injection of any illegal drug or distributing bleach for the purpose of cleaning needles for such injections, or, to carry out (AIDS) testing unless such testing is accompanied by appropriate pre-test counseling and appropriate post-test counseling."

Contract language for providers who received federal Block Grant funds and who served IVDUs included the requirement that they were to notify DBH upon reaching 90% of their capacity to admit individuals to the program. Additionally, contract monitors review capacity as part of their annual review process (as well as monitoring utilization on an ad hoc basis through examination of active clients within the MIS system). Programs (including the State 800#/Helpline) and/or individual clients routinely contact DBH, which brokers admissions to service in emergencies for assistance in accessing treatment. Due to lack of funding and personnel, we have been unable to establish an effective and efficient waiting list management program.

All contracts with programs funded by Block Grant funds included language requiring that providers make every attempt to admit individuals within 14 days after making the request for admission, or 120 days after the request if interim services are provided. The contract further defines what interim services are to be provided. Monitors review this activity as part of their annual review process. Additionally, DBH staff routinely assists consumers and their family members in accessing services in emergency situations.

The State has a single contractor for statewide detoxification services. The contractspecifies that detoxification services must be provided on demand. For contract monitoring purposes, this means that a client must be admitted within 48 hours of requesting service.

All contracts with programs funded by Block Grant funds included language requiring that they conduct outreach activities to intercede specifically with IVDUs, in order to provide HIV counseling, and refer individuals to treatment, or medical/other support. Although not funded by DBH, the Department of Health (DOH) and their community programs provide a wide range of street outreach activities to intravenous drug users designed to reduce harm and refer IVDUs to treatment DBH and DOH regularly collaborate. DBH staff regularly attends DOH committee meetings targeting the injection drug user population, specifically, the IVDU Task Force and the Rhode Island Community Planning Group for HIV Prevention. State and federal funds were reallocated across the state to improve access to services. This action was a response to the

"Rhode Island Methadone Treatment Report", provided by Health and Addiction Research Inc. and funded by CSAT technical assistance initiative.

FFY2006- Progress

Continued to provide services at methadone clinics provided by CODAC II, III, IV, and 5, as well as funding all methadone programs through the reunification program with DCYF. Also continued to provide services in drug-free and medical detoxification settings for individuals who use illicit drugs intravenously or engage in risky behavior.

DBH staff continued to meet with clinical managers of opioid treatment programs to discuss patient care issues and to improve the quality of Opiate Treatment Services. DBH staff continued to attend the monthly Opioid Treatment Program (OTP) provider meeting. This is an opportunity to address clinical service issues as well as offer technical assistance. DBH staff continued to assist in the preparation of OTPs to meet CSAT regulations regarding accreditation. To date, all opioid treatment programs have had positive accreditation outcomes.

The DBH staff and Department of Health (DOH) staff continued to work collaboratively on a Cross training initiative through the Drug and Alcohol Treatment Association of RI (DATA). This initiative addressed substance abuse and infectious disease issues. The primary purpose of the initiative was the prevention and care of behavioral healthcare issues and infectious diseases, and was based on the curriculum developed by the Substance Abuse and Mental Health Administration (SAMHSA) and the Center for Disease Control and Prevention (CDC). Trainings have been offered in October/November 2005. They were well attended. The evaluations have been very good.

Several workgoups, in collaboration with DOH, were developed to address the needs of injection drug users. They are the HIV Provision of Care workgroup, the Injection Drug User Task Force, the Viral Hepatitis Advisory Group, and the Methamphetamine Task Force. These workgroups consist of DBH staff, DOH staff, substance abuse treatment providers, other community organizations and consumers. One of our goals is to improve outreach activities to better engage injection drug users into treatment. One of our providers has successfully secured funding from CDC, CSAT, and the Rhode Island Department of Health to reach this population
Recent provider collaborations have occurred to address the increasing concern for adolescent opioid abuse. Discovery House, a methadone treatment provider, has joined forces with Caritas House, a provider of inpatient and outpatient adolescent treatment services, to offer a unique program combining outpatient methadone withdrawal with adolescent intensive outpatient services.

DBH continued to provide interim services involving individualized based assessment of need and symptom severity are provided for Rhode Island residents awaiting substance abuse

treatment services. Self-pay options exist for people awaiting state-funded treatment at any of our outpatient providers, including methadone maintenance treatment; outpatient capacity is not as finite as it is in residential treatment. Some regions have developed orientation groups as interim services for individuals awaiting admission. These groups provide clients with clear expectations of the treatment experience and provide for crisis intervention. The state-contracted detoxification provider has used sleepover partial hospitalization beds as interim care for clients awaiting admission into residential treatment. Individuals are stepped-down to this level of care if the discharge plan calls for residential treatment and the bed is not immediately available, but will be shortly. When the wait for residential treatment may be longer, the detox contractor, along with other referring agents, may refer clients to the transitional beds available at our contracted long-term care facility. These beds, housed at The Providence Center's long-term care residential program are designated specifically for that purpose.

FFY2007 - Intended

DBH will continue to provide specialized services for IVDUs in both narcotic treatment (methadone) and drug-free programs throughout Rhode Island. The "Rhode Island Methadone Treatment Report" indicates that patients in our opioid treatment agencies have access to HIV/AIDS and TB services. Recommendations included improving education regarding risk factors regarding Viral Hepatitis. CODAC treatment centers have been and will continue to offer HepB vaccines for all appropriate patients in their opioid treatment programs. The Rhode Island Department of Health has secured funding for HepB vaccines to be offered in two sites.

DBH will continue to encourage substance abuse providers to attend training for substance abuse and infectious disease issues at DATA and funded by the Department of Health through the Project Reach program. These trainings are funded by the Department of Health through the Project Reach program.

DBH will continue to collaborate with the DOH on workgroups to improve outreach activities to better engage injection drug users into treatment.

DBH will continue to provide interim services involving individualized based assessment of need and symptom severity are provided for Rhode Island residents awaiting substance abuse treatment services. Self-pay options exist for people awaiting state-funded treatment at any of our outpatient providers, including methadone maintenance treatment; outpatient capacity is not as finite as it is in residential treatment. Some regions have developed orientation groups as interim services for individuals awaiting admission. These groups provide clients with clear expectations of the treatment experience and provide for crisis intervention. The state-contracted detoxification provider has used sleepover partial hospitalization beds as interim care for clients awaiting admission into residential treatment. Individuals are stepped-down to this level of care if the discharge plan calls for residential treatment and the bed is not immediately available, but

will be shortly. When the wait for residential treatment may be longer, the detox contractor, along with other referring agents, may refer clients to the transitional beds available at our contracted long-term care facility. These beds, housed at The Providence Center's long-term care residential program are designated specifically for that purpose.

Attachment G: Capacity Management & Waiting List Systems

The Rhode Island Department of Mental Health, Retardation and Hospitals - Division of Behavioral Healthcare Services has undertaken the following steps regarding Capacity Management and Waiting List Systems:

- maintaining and ongoing monitoring of utilization data in DBH's Client InformationSystem (CIS). The CIS collects active client caseload information from all contract programs using a unique client identifier - three initials and last four digits of social security - for all admissions and discharges. DBH has implemented a revised, accelerated schedule on submitting utilization data. The schedule which follows, has enhanced our oversight of utilization system-wide and by program by assuring that the data is current:

    - real time for detoxification services,
    - **daily** for Narcotic Treatment Programs,
    - monthly for outpatient programs, and
    - monthly for residential programs

While the CIS is not currently specifically set-up to collect and process data to meet Capacity and Waiting List Management Systems needs in an automated manner, the currency of the information and the continuous comparison of each programs current utilization versus capacity provides DBH the means to pro-actively address service issues. Also, capacity is almost always an issue in residential settings where the maximum number of beds is established two ways: one by license and secondly by the facility=s physical capacity. Capacity is almost never an issue in outpatient settings because there is no capacity established in licensing and physical capacity can be addressed operationally, e.g. through scheduling/staggering clinical appointments. Thus the primary area at issue is the residential program settings.

The State has a single contractor for statewide detoxification services. The contract, a global capitated at-risk, specifies that detoxification services must be provided on demand. For contract monitoring purposes, this means that a client must be admitted within 48 hours of requesting service.

The DBH functions as the central registry for all methadone programs licensed in the State. Through this activity, DBH is in almost daily contact with narcotic treatment programs. As a component of this clearing process, the methadone programs must be contact with each other. This further insures that clients requesting admission into an IVDU program is handled in the most expeditious manner.

Contract language, which specifies admission preference - in addition to the Block Grant priority populations requirements, specifies other additional populations and financial eligibility, which insures the most needy are served. The contract also requires the provision of interim services when the program reaches capacity and cannot be admitted, and the maintenance of a waiting list, identifying each client by the unique client identifier.

By conducting onsite Program Monitoring and regular meetings with drug-free treatment programs, the DBH has continuous information on the relationship of capacity to demand in each program. Through the regular meetings, DBH is able to prospectively ascertain when programs are approaching 90.0 percent of capacity. Also, during the onsite monitoring visit the review ascertains whether the program complied with contract requirements identified above.

As only residential programs generally have a defined finite capacity, the inability to admit clients requesting treatment are limited to this service category, and DBH maintains ongoing communications and oversight of utilization through the CIS and contacts with the agencies. Pregnant women may be placed on a waiting list for Sstarbirth, our contract residential treatment provider for pregnant and post-partum women. Upon assessment, women are referred to other residential treatment programs for interim services and are prioritized for admission. All levels of outpatient treatment may be utilized as interim services for women who are awaiting placement at Sstarbirth.

Contract language for the new GOP system specifies that if the Provider's static capacity is over subscribed, a wait list for services may be established. However, before a client is wait listed for a service, the Provider will determine if there exists capacity at another Department Provider in a region the client could travel to. Static and dynamic capacity is reviewed on a monthly basis for the each of the GOP prime contractors. Prime Contractors are also required to complete quarterly reports to the Department of MHRH, Division of Behavioral Healthcare outlining the number of weekly assessments, admissions, discharges and census data along with frequency of clinical services.

In Rhode Island, for all practical purposes all pregnant women are covered for substance abuse services outside of the publicly funded substance abuse system. Specifically, while the income limit for indigent services is 200 percent of the Federal Poverty Level, other public and private initiatives cover pregnant women in effect provide universal coverage:

- pregnant and women with children with income under 250 percent of the Federal Poverty Level are covered under the RIte Care Program, this State=s approved 1115 Medicaid waiver program. Under RIte Care all substance abuse treatment services are in-plan.

- pregnant women in households between 251 and 350 percent of the Federal Poverty Level are eligible for RIte Care Program during the period of the pregnancy. Under this situation,

the women are eligible for the same array of services as the first group, to include a full range of substance abuse treatment services.

Under RIte Care, the Managed Care Operator is able to contract with any provider for the provision of required substance abuse treatment services. As such, services may be provided in programs not part of the publicly funded system. The Rhode Island Department of Human Services (DHS), the agency which administers the RIte Care Program, continuously monitors access and utilization of services, and through these processes, is able to insure access to necessary and clinically appropriate services.

Although pregnant women are receiving required substance abuse treatment services under other auspices, when conducting on-site monitoring, DBH's monitors confirm the preferential admission policy, and the treatment agency's policy(ies) and practices on maintaining contact and providing interim services to applicants awaiting admission into treatment. Further, through a review of case records, DBH is able to affirm that these requirements are fully met.

Through these continuous and active processes, the DBH and in the case of DHS for substance abuse treatment services for pregnant women, the State of RI has implemented steps to address interim services needs and services to pregnant women as prescribed under 45 C. F. R. 96.126(c) for intravenous drug services and 45 C. F. R. 96.131(c) for services for pregnant women.

GOAL # 4

-- An agreement to provide treatment to intravenous drug abusers that fulfills the 90 percent capacity reporting, 14-120 day performance requirement, interim services, outreach activities and monitoring requirements (See 42 U.S.C. 300x-23 and 45 C.F.R. 96.126).

FFY 2004 (Compliance):

FFY 2006 (Progress):

FFY 2007 (Intended Use):

GOAL # 4. An agreement to provide treatment to intravenous drug abusers that fulfills the 90 percent capacity reporting, 14-20 day performance requirement, interim services, outreach activities and monitoring requirements.

In FFY2004, the state:

- continued activity in Attachment C
- continued activity in Attachment G
- Required contracted programs that treat individuals for intravenous drug use provide the above referenced services.
- continued collaboration with the Department of Health's ENCORprogram (Education, Needle Exchange, Counseling, Outreach and Referral) which is an HIV (and other Blood-borne pathogens) prevention/intervention aimed at injecting drug users (note: no Block Grant dollars were used for needle exchange activity)

In FFY2006, the state:

- Continues activity in Attachment C
- Continues activity in Attachment G
- Requires contracted programs that treat individuals for intravenous drug use provide the above referenced services.
- Continues collaboration with the Department of Health's ENCORprogram (Education, Needle Exchange, Counseling, Outreach and Referral) which is an HIV (and other Blood-borne pathogens) prevention/intervention aimed at injecting drug users (note: no Block Grant dollars were used for needle exchange activity)

In FFY2007, the state will:

- Continue activity in Attachment C

- Continue activity in Attachment G
- Require contracted programs that treat individuals for intravenous drug use provide the above referenced services.
- Continue collaboration with the Department of Health's ENCORprogram (Education, Needle Exchange, Counseling, Outreach and Referral) which is an HIV (and other Blood-borne pathogens) prevention/intervention aimed at injecting drug users (note: no Block Grant dollars were used for needle exchange activity)

ATTACHMENT C: PROGRAMS FOR INTRAVENOUS DRUG USERS

FFY2004 - Compliance

Utilizing the federal definitions in effect in 1991 for targeting IVDUs, the state defined its IVDU initiative to include individuals identified within treatment programs with either primary or secondary drug problems which included intravenous drug use. While a large portion of IVDU set-aside funds were allocated for primary IVDUs in methadone treatment, funding was also allocated to drug-free modalities serving IVDUs throughout the state. Additionally, DBH was committed to training all of its service providers on AIDS related issues, so that HIV infected clients and other high risk populations accessing all modalities could effectively be served either within treatment programs, or referred to appropriate medical and support services.

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Block Grant Support: $666,590

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Fee for Service methadone maintenance and related HIV services for parenting women in treatment working with DCYF toward reunification with their children.

Block Grant Support: $358

SSTAR DETOX

Block Grant support: $749,580
Total IVDU Block Grant support: $1,416,528

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"Rhode Island Methadone Treatment Report", provided by Health and Addiction Research Inc. and funded by CSAT technical assistance initiative.

FFY2006- Progress

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FFY2007 - Intended

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    - real time for detoxification services,
    - **daily** for Narcotic Treatment Programs,
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Contract language, which specifies admission preference - in addition to the Block Grant priority populations requirements, specifies other additional populations and financial eligibility, which insures the most needy are served. The contract also requires the provision of interim services when the program reaches capacity and cannot be admitted, and the maintenance of a waiting list, identifying each client by the unique client identifier.

By conducting onsite Program Monitoring and regular meetings with drug-free treatment programs, the DBH has continuous information on the relationship of capacity to demand in each program. Through the regular meetings, DBH is able to prospectively ascertain when programs are approaching 90.0 percent of capacity. Also, during the onsite monitoring visit the review ascertains whether the program complied with contract requirements identified above.

As only residential programs generally have a defined finite capacity, the inability to admit clients requesting treatment are limited to this service category, and DBH maintains ongoing communications and oversight of utilization through the CIS and contacts with the agencies. Pregnant women may be placed on a waiting list for Sstarbirth, our contract residential treatment provider for pregnant and post-partum women. Upon assessment, women are referred to other residential treatment programs for interim services and are prioritized for admission. All levels of outpatient treatment may be utilized as interim services for women who are awaiting placement at Sstarbirth.

Contract language for the new GOP system specifies that if the Provider's static capacity is over subscribed, a wait list for services may be established. However, before a client is wait listed for a service, the Provider will determine if there exists capacity at another Department Provider in a region the client could travel to. Static and dynamic capacity is reviewed on a monthly basis for the each of the GOP prime contractors. Prime Contractors are also required to complete quarterly reports to the Department of MHRH, Division of Behavioral Healthcare outlining the number of weekly assessments, admissions, discharges and census data along with frequency of clinical services.

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- pregnant women in households between 251 and 350 percent of the Federal Poverty Level are eligible for RIte Care Program during the period of the pregnancy. Under this situation,

the women are eligible for the same array of services as the first group, to include a full range of substance abuse treatment services.

Under RIte Care, the Managed Care Operator is able to contract with any provider for the provision of required substance abuse treatment services. As such, services may be provided in programs not part of the publicly funded system. The Rhode Island Department of Human Services (DHS), the agency which administers the RIte Care Program, continuously monitors access and utilization of services, and through these processes, is able to insure access to necessary and clinically appropriate services.

Although pregnant women are receiving required substance abuse treatment services under other auspices, when conducting on-site monitoring, DBH's monitors confirm the preferential admission policy, and the treatment agency's policy(ies) and practices on maintaining contact and providing interim services to applicants awaiting admission into treatment. Further, through a review of case records, DBH is able to affirm that these requirements are fully met.

Through these continuous and active processes, the DBH and in the case of DHS for substance abuse treatment services for pregnant women, the State of RI has implemented steps to address interim services needs and services to pregnant women as prescribed under 45 C. F. R. 96.126(c) for intravenous drug services and 45 C. F. R. 96.131(c) for services for pregnant women.

Rhode Island

Goal #5: TB Services

GOAL # 5. An agreement, directly or through arrangements with other public or nonprofit private entities, to routinely make available tuberculosis services to each individual receiving treatment for substance abuse and to monitor such service delivery (See 42 U.S.C. 300x-24(a) and 45 C.F.R. 96.127).

FY 2004 (Compliance):

FY 2006 (Progress):

FY 2007 (Intended Use):

GOAL # 5

-- An agreement, directly or through arrangements with other public or nonprofit private entities, to routinely make available tuberculosis services to each individual receiving treatment for substance abuse and to monitor such service delivery (See 42 U.S.C. 300x-24(a) and 45 C.F.R. 96.127).

FFY 2004 (Compliance):

FFY 2006 (Progress):

FFY 2007 (Intended Use):

GOAL # 5. An agreement, directly or through arrangements with other public or nonprofit private entities, to routinely make available tuberculosis services to each individual receiving treatment for substance abuse and to monitor such service delivery.

In FFY2004, the states:

- see Attachment D: Program Compliance Monitoring
- see Attachment E: Tuberculosis (TB) and Early Intervention Services for HIV
- Contracts required programs to make referrals for TB services.

Attachment D: Compliance Monitoring

Notification of Reaching Capacity

The Rhode Island Department of Mental Health, Retardation and Hospitals - Division of Behavioral Health (DBH) notification of reaching capacity includes:

compiling program utilization data in DSA s Client Information System (CIS). The CIS captures active client caseloads in all contract programs. The CIS requires treatment programs to submit admission and discharge data using a unique client identifier on a defined schedule:

- real time for detoxification services,
- **daily** for Narcotic Treatment Programs,
- monthly for outpatient programs, and
- monthly for residential programs

While the CIS is not currently configured to collect and process data for Capacity and Waiting List Management Systems requirements in an automated manner, the currency of the information

and the continuous comparison of each program's current utilization versus capacity provides DBH the means to pro-actively address service issues. Also, capacity is almost always an issue in residential settings where the maximum number of beds is established two ways: one by license and secondly by the facility physical capacity. Capacity is almost never an issue in outpatient settings because there is no capacity established in licensing and physical capacity can be addressed operationally, e.g. through scheduling clinical appointments. Thus the primary area at issue is the residential program settings.

Through contract, providers are required to contact the Department when they reach 90 percent capacity. The prime contractors under the GOP have been instructed to notify the Department whenever the wait for service exceeds 21 calendar days.

Tuberculosis Services

All methadone, residential, and medical detoxification treatment programs are required by licensing regulations to provide a pre-admission physical, which includes necessary laboratory work to include tuberculosis (PPD-Mantoux) testing. In addition, the contracts with treatment programs specify that the program must routinely make available tuberculosis services directly or through arrangements with other entities to all individuals receiving treatment for substance abuse.

Department staff routinely assesses compliance with Federal regulations and state contract and licensing requirements during compliance site visits.

Treatment Services for Pregnant Women

In Rhode Island, all pregnant women under 250 percent of the Federal Poverty Level are covered under the RIte Care Program, the State's approved 1115 Medicaid waiver program. RIte Care covers all primary health care and substance abuse treatment services. Under RIte Care, the Managed Care Operator is able to contract with any provider for the provision of required substance abuse treatment services. As such, services may be provided outside the publicly funded system. The Rhode Island Department of Human Services (DHS), the agency which administers the RIte Care Program, continuously monitors access and utilization of services, and through these processes, is able to insure access to necessary and clinically appropriate services.

Through these continuous and active processes, the DBH and in the case of DHS for substance abuse treatment services for pregnant women, the State of RI has positioned itself to insure access to services and address the requirements under 45 C. F. R. 96.126(c) for intravenous drug services and 45 C. F. R. 96.131(c) for services for pregnant women.

As mentioned in previous sections, the Department routinely assesses compliance with Federal regulations and state contract and licensing requirements as an integral part of its monitoring and compliance site visits.

ATTACHMENT E: TUBERCULOSIS (TB) AND EARLY INTERVENTION SERVICES FOR HIV

FFY2004- Compliance

Due to funding limitations, on-site TB services are not routinely provided at all substance abuse treatment sites. However, all residential and methadone maintenance treatment programs are required, under licensing regulations, to provide, or receive recent documentation of, a pre-admission physical, which includes laboratory work related to tuberculosis (PPD-Mantoux). In addition, all contracted treatment programs receiving Block Grant and/or state funding are contractually obligated to "routinely make available tuberculosis services directly or through arrangements with other public or non-profit entities to all individuals receiving treatment for substance abuse. Services shall include counseling; testing to determine whether the individual has been infected with mycobacteria tuberculosis to determine the appropriate form of treatment, and referral of individuals infected by TB for appropriate medical evaluation and treatment." On-site tuberculosis services are provided at all of CODAC's methadone maintenance sites, in Providence (RI900629), East Providence, Newport, and Wakefield. These programs serve a significant number of clients who are at risk for contracting TB. All programs statewide have access to the state TB clinic located at Roger Williams Hospital in Providence, which is funded by the SSA for public health and communicable diseases (i.e., the Department of Health (DOH)). The Single State Authority for Substance Abuse (i.e., Division of Behavioral Healthcare) regularly confers with staff at the DOH Division of Disease Prevention and Control on TB issues, access, etc., and TB staff have provided consultation to providers on specific areas of concern. Due to funding limitations, no Block Grant funds have specifically been earmarked for TB services. Funding for TB services is derived from the Division of Disease Prevention and Control (DOH DDPC). (Please note that this funding is not limited to TB services for substance abusers, but is available to all Rhode Islanders at high risk for contracting TB.)

During FY04, collaborative training for the state's substance abuse providers was conducted by members of DBH staff and DOH's Division of Disease Prevention and Control (DDPC). This training addressed both prevention and treatment issues related to TB, as well as disseminating information about resources in the state. Rhode Island incorporates its TB training with training related to HIV prevention, early intervention and treatment, harm reduction, Hepatitis A, B & C and STDs, since consumers are at risk for all these diseases, and approaches and resources are related.

Early Intervention Services for HIV were provided at CODAC's methadone maintenance sites in Providence (RI900629), Newport (RI301406), East Bay (RI900975), and Wakefield (CODAC is the state's largest methadone program serving intravenous drug users). All other licensed programs are required to provide or arrange for pre-test and post-test counseling and testing for

HIV for individuals at risk. CODAC as well as other statewide licensed treatment programs collaborate with the Health Department's ENCORE program, which provides HIV outreach, harm reduction and referral for medical and substance abuse treatment services. Technical assistance is provided through ad hoc trainings for individual treatment programs. Additionally, many providers and DBH staff are active in the Department of Health's HIV Community Planning Group (CPG), which annually publishes a Comprehensive Plan for HIV Prevention, which addresses HIV issues related to high risk populations, such as substance abusers, racial and ethnic minorities, youth and other special populations. This group is instrumental in identifying barriers and finding solutions to treatment access, outreach strategies, harm reduction, information dissemination, etc., and serves as a valuable technical assistance mechanism.

DBH staff is active on the Department of Health's Provision of Care (POC) Committee, which meets monthly to address future RFP opportunities as well as estimating and assessing unmet need for HIV positive population. This committee develops the Health Resources and Services Administration (HRSA) annual unmet needs report. Another collaborative initiative between the DBH and DOH is the Injection Drug User (IDU) Task Force. This task force has held focus groups with providers and clients to identify problems and issues around access to services, substance abuse treatment provider training issues, syringe exchange, and the injection drug user population in the prison system. The next step will be for the task force member to create logic models with related strategies to address gaps and create desired outcomes.

FFY2006 - Progress

One recent procedural change was the development of the supportive referral services form by DBH staff. The intent of this new form is for our substance abuse treatment programs to provide clients with referrals for HIV, HCV, TB, and STD testing sites. This was implemented in response to federal guidelines. Also during this time period, additional trainings on HIV, TB, Hepatitis and STDs were provided through a number of mechanisms, including training offered at the New England School of Addiction Studies summer school and school for Best Practices, along with the Project Reach through the Drug and Alcohol Treatment Association. DBH continues to collaborate with the Department of Health on emerging issues related to HIV, TB and other infectious diseases affecting the substance abusing population, and regularly shares information with providers DBH also hosts an ongoing group of providers and staff from the department of Health to keep abreast of new treatments, risks and issues related to substance abuse and infectious diseases, including TB. Information is regularly shared with the treatment network.

The Division of Behavioral Healthcare provided notification to the treatment community on HIV/Behavioral Healthcare specific trainings offered through Project Reach. Documentation of HIV training is required for certification as a chemical dependency professional in the State of Rhode Island.

DBH Substance Abuse Treatment Unit staff met with representative of Project Vista, a program connected with Miriam Hospital, and gave technical assistance on recruitment of participants for HIV early intervention services. Project Vista is based in Providence and coordinates care with Sstar, the state funded medical detoxification provider, and CODAC, the state's largest provider of methadone treatment services. Vista helped to connect eligible individuals with longer-term outpatient methadone withdrawal and maintenance along with providing vital case management services. Participants were connected with emergency shelters and permanent sober housing. Vista also supported psychiatric treatment for participants with co-occurring disorders. The Afia Center is a drop-in center located in downtown Providence which provided case management and education/counseling services to HIV positive and high risk individuals. All individuals are provided with referrals for HIV testing and necessary medical care.

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DBH staff is active on the Department of Health's Viral Hepatitis Advisory Group (VHAG), which meets monthly. This advisory group has identified needs and gaps of viral hepatitis prevention and treatment services in our state. This group is also has the goal of developing a strategic plan addressing a comprehensive approach to patient care with subcommittees on prevention, service delivery, policy/payer affairs and epidemiology.

- Rhode Island is not a CSAT-designated HIV state.
- Contract required programs to make referrals for TB services.

FFY2007 - Intended

Procedures and activities will be continued as in prior years. Training and information on TB issues continues to be incorporated into courses sponsored by the Drug and Alcohol Treatment

Association (DATA) for Rhode Island's provider network, particularly within existing curriculum addressing HIV/AIDS & Hepatitis C. The provider network then incorporates education, testing and referrals at the program level. Rhode Island will continue to require HIV training as a requirement as certification as a chemical dependency professional.

The Division of Behavioral Healthcare will continue to collaborate and provide technical assistance to innovative early intervention and outreach programs such as Project Vista and MAP outreach.

DBH will assemble a state-wide committee to include other state department and providers to address the increase of our youth abusing opioids. We will continue to analyze data and trends and plan on prevention and intervention strategies.

- According to our project officer, Rhode Island is not a HIV designated state.
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In FFY2006, the states continue:

- see Attachment D: Program Compliance Monitoring
- see Attachment E: Tuberculosis (TB) and Early Intervention Services for HIV
- Contracting required programs to make referrals for TB services.

Attachment D: Compliance Monitoring

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FFY2006 - Progress

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- Rhode Island is not a CSAT-designated HIV state.
- Contract required programs to make referrals for TB services.

FFY2007 - Intended

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In FFY2007, the state will:

- Continue to require in the contract that sub-contractors routinely make available tuberculosis services directly or through arrangements with other public or non-profit private entities to all individuals receiving treatment for substance abuse.
- see Attachment D: Program Compliance Monitoring
- see Attachment E: Tuberculosis (TB) and Early Intervention Services for HIV

Attachment D: Compliance Monitoring

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FFY2007 - Intended

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GOAL # 5

-- An agreement, directly or through arrangements with other public or nonprofit private entities, to routinely make available tuberculosis services to each individual receiving treatment for substance abuse and to monitor such service delivery (See 42 U.S.C. 300x-24(a) and 45 C.F.R. 96.127).

FFY 2004 (Compliance):

FFY 2006 (Progress):

FFY 2007 (Intended Use):

GOAL # 5. An agreement, directly or through arrangements with other public or nonprofit private entities, to routinely make available tuberculosis services to each individual receiving treatment for substance abuse and to monitor such service delivery.

In FFY2004, the states:

- see Attachment D: Program Compliance Monitoring
- see Attachment E: Tuberculosis (TB) and Early Intervention Services for HIV
- Contracts required programs to make referrals for TB services.

Attachment D: Compliance Monitoring

Notification of Reaching Capacity

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compiling program utilization data in DSA s Client Information System (CIS). The CIS captures active client caseloads in all contract programs. The CIS requires treatment programs to submit admission and discharge data using a unique client identifier on a defined schedule:

- real time for detoxification services,
- **daily** for Narcotic Treatment Programs,
- monthly for outpatient programs, and
- monthly for residential programs

While the CIS is not currently configured to collect and process data for Capacity and Waiting List Management Systems requirements in an automated manner, the currency of the information

and the continuous comparison of each program's current utilization versus capacity provides DBH the means to pro-actively address service issues. Also, capacity is almost always an issue in residential settings where the maximum number of beds is established two ways: one by license and secondly by the facility physical capacity. Capacity is almost never an issue in outpatient settings because there is no capacity established in licensing and physical capacity can be addressed operationally, e.g. through scheduling clinical appointments. Thus the primary area at issue is the residential program settings.

Through contract, providers are required to contact the Department when they reach 90 percent capacity. The prime contractors under the GOP have been instructed to notify the Department whenever the wait for service exceeds 21 calendar days.

Tuberculosis Services

All methadone, residential, and medical detoxification treatment programs are required by licensing regulations to provide a pre-admission physical, which includes necessary laboratory work to include tuberculosis (PPD-Mantoux) testing. In addition, the contracts with treatment programs specify that the program must routinely make available tuberculosis services directly or through arrangements with other entities to all individuals receiving treatment for substance abuse.

Department staff routinely assesses compliance with Federal regulations and state contract and licensing requirements during compliance site visits.

Treatment Services for Pregnant Women

In Rhode Island, all pregnant women under 250 percent of the Federal Poverty Level are covered under the RIte Care Program, the State's approved 1115 Medicaid waiver program. RIte Care covers all primary health care and substance abuse treatment services. Under RIte Care, the Managed Care Operator is able to contract with any provider for the provision of required substance abuse treatment services. As such, services may be provided outside the publicly funded system. The Rhode Island Department of Human Services (DHS), the agency which administers the RIte Care Program, continuously monitors access and utilization of services, and through these processes, is able to insure access to necessary and clinically appropriate services.

Through these continuous and active processes, the DBH and in the case of DHS for substance abuse treatment services for pregnant women, the State of RI has positioned itself to insure access to services and address the requirements under 45 C. F. R. 96.126(c) for intravenous drug services and 45 C. F. R. 96.131(c) for services for pregnant women.

As mentioned in previous sections, the Department routinely assesses compliance with Federal regulations and state contract and licensing requirements as an integral part of its monitoring and compliance site visits.

ATTACHMENT E: TUBERCULOSIS (TB) AND EARLY INTERVENTION SERVICES FOR HIV

FFY2004- Compliance

Due to funding limitations, on-site TB services are not routinely provided at all substance abuse treatment sites. However, all residential and methadone maintenance treatment programs are required, under licensing regulations, to provide, or receive recent documentation of, a pre-admission physical, which includes laboratory work related to tuberculosis (PPD-Mantoux). In addition, all contracted treatment programs receiving Block Grant and/or state funding are contractually obligated to "routinely make available tuberculosis services directly or through arrangements with other public or non-profit entities to all individuals receiving treatment for substance abuse. Services shall include counseling; testing to determine whether the individual has been infected with mycobacteria tuberculosis to determine the appropriate form of treatment, and referral of individuals infected by TB for appropriate medical evaluation and treatment." On-site tuberculosis services are provided at all of CODAC's methadone maintenance sites, in Providence (RI900629), East Providence, Newport, and Wakefield. These programs serve a significant number of clients who are at risk for contracting TB. All programs statewide have access to the state TB clinic located at Roger Williams Hospital in Providence, which is funded by the SSA for public health and communicable diseases (i.e., the Department of Health (DOH)). The Single State Authority for Substance Abuse (i.e., Division of Behavioral Healthcare) regularly confers with staff at the DOH Division of Disease Prevention and Control on TB issues, access, etc., and TB staff have provided consultation to providers on specific areas of concern. Due to funding limitations, no Block Grant funds have specifically been earmarked for TB services. Funding for TB services is derived from the Division of Disease Prevention and Control (DOH DDPC). (Please note that this funding is not limited to TB services for substance abusers, but is available to all Rhode Islanders at high risk for contracting TB.)

During FY04, collaborative training for the state's substance abuse providers was conducted by members of DBH staff and DOH's Division of Disease Prevention and Control (DDPC). This training addressed both prevention and treatment issues related to TB, as well as disseminating information about resources in the state. Rhode Island incorporates its TB training with training related to HIV prevention, early intervention and treatment, harm reduction, Hepatitis A, B & C and STDs, since consumers are at risk for all these diseases, and approaches and resources are related.

Early Intervention Services for HIV were provided at CODAC's methadone maintenance sites in Providence (RI900629), Newport (RI301406), East Bay (RI900975), and Wakefield (CODAC is the state's largest methadone program serving intravenous drug users). All other licensed programs are required to provide or arrange for pre-test and post-test counseling and testing for

HIV for individuals at risk. CODAC as well as other statewide licensed treatment programs collaborate with the Health Department's ENCORE program, which provides HIV outreach, harm reduction and referral for medical and substance abuse treatment services. Technical assistance is provided through ad hoc trainings for individual treatment programs. Additionally, many providers and DBH staff are active in the Department of Health's HIV Community Planning Group (CPG), which annually publishes a Comprehensive Plan for HIV Prevention, which addresses HIV issues related to high risk populations, such as substance abusers, racial and ethnic minorities, youth and other special populations. This group is instrumental in identifying barriers and finding solutions to treatment access, outreach strategies, harm reduction, information dissemination, etc., and serves as a valuable technical assistance mechanism.

DBH staff is active on the Department of Health's Provision of Care (POC) Committee, which meets monthly to address future RFP opportunities as well as estimating and assessing unmet need for HIV positive population. This committee develops the Health Resources and Services Administration (HRSA) annual unmet needs report. Another collaborative initiative between the DBH and DOH is the Injection Drug User (IDU) Task Force. This task force has held focus groups with providers and clients to identify problems and issues around access to services, substance abuse treatment provider training issues, syringe exchange, and the injection drug user population in the prison system. The next step will be for the task force member to create logic models with related strategies to address gaps and create desired outcomes.

FFY2006 - Progress

One recent procedural change was the development of the supportive referral services form by DBH staff. The intent of this new form is for our substance abuse treatment programs to provide clients with referrals for HIV, HCV, TB, and STD testing sites. This was implemented in response to federal guidelines. Also during this time period, additional trainings on HIV, TB, Hepatitis and STDs were provided through a number of mechanisms, including training offered at the New England School of Addiction Studies summer school and school for Best Practices, along with the Project Reach through the Drug and Alcohol Treatment Association. DBH continues to collaborate with the Department of Health on emerging issues related to HIV, TB and other infectious diseases affecting the substance abusing population, and regularly shares information with providers DBH also hosts an ongoing group of providers and staff from the department of Health to keep abreast of new treatments, risks and issues related to substance abuse and infectious diseases, including TB. Information is regularly shared with the treatment network.

The Division of Behavioral Healthcare provided notification to the treatment community on HIV/Behavioral Healthcare specific trainings offered through Project Reach. Documentation of HIV training is required for certification as a chemical dependency professional in the State of Rhode Island.

DBH Substance Abuse Treatment Unit staff met with representative of Project Vista, a program connected with Miriam Hospital, and gave technical assistance on recruitment of participants for HIV early intervention services. Project Vista is based in Providence and coordinates care with Sstar, the state funded medical detoxification provider, and CODAC, the state's largest provider of methadone treatment services. Vista helped to connect eligible individuals with longer-term outpatient methadone withdrawal and maintenance along with providing vital case management services. Participants were connected with emergency shelters and permanent sober housing. Vista also supported psychiatric treatment for participants with co-occurring disorders. The Afia Center is a drop-in center located in downtown Providence which provided case management and education/counseling services to HIV positive and high risk individuals. All individuals are provided with referrals for HIV testing and necessary medical care.

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DBH staff is active on the Department of Health's Viral Hepatitis Advisory Group (VHAG), which meets monthly. This advisory group has identified needs and gaps of viral hepatitis prevention and treatment services in our state. This group is also has the goal of developing a strategic plan addressing a comprehensive approach to patient care with subcommittees on prevention, service delivery, policy/payer affairs and epidemiology.

- Rhode Island is not a CSAT-designated HIV state.
- Contract required programs to make referrals for TB services.

FFY2007 - Intended

Procedures and activities will be continued as in prior years. Training and information on TB issues continues to be incorporated into courses sponsored by the Drug and Alcohol Treatment

Association (DATA) for Rhode Island's provider network, particularly within existing curriculum addressing HIV/AIDS & Hepatitis C. The provider network then incorporates education, testing and referrals at the program level. Rhode Island will continue to require HIV training as a requirement as certification as a chemical dependency professional.

The Division of Behavioral Healthcare will continue to collaborate and provide technical assistance to innovative early intervention and outreach programs such as Project Vista and MAP outreach.

DBH will assemble a state-wide committee to include other state department and providers to address the increase of our youth abusing opioids. We will continue to analyze data and trends and plan on prevention and intervention strategies.

- According to our project officer, Rhode Island is not a HIV designated state.
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In FFY2006, the states continue:

- see Attachment D: Program Compliance Monitoring
- see Attachment E: Tuberculosis (TB) and Early Intervention Services for HIV
- Contracting required programs to make referrals for TB services.

Attachment D: Compliance Monitoring

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- Contract required programs to make referrals for TB services.

FFY2007 - Intended

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In FFY2007, the state will:

- Continue to require in the contract that sub-contractors routinely make available tuberculosis services directly or through arrangements with other public or non-profit private entities to all individuals receiving treatment for substance abuse.
- see Attachment D: Program Compliance Monitoring
- see Attachment E: Tuberculosis (TB) and Early Intervention Services for HIV

Attachment D: Compliance Monitoring

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- Contract required programs to make referrals for TB services.

FFY2007 - Intended

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GOAL # 5

-- An agreement, directly or through arrangements with other public or nonprofit private entities, to routinely make available tuberculosis services to each individual receiving treatment for substance abuse and to monitor such service delivery (See 42 U.S.C. 300x-24(a) and 45 C.F.R. 96.127).

FFY 2004 (Compliance):

FFY 2006 (Progress):

FFY 2007 (Intended Use):

GOAL # 5. An agreement, directly or through arrangements with other public or nonprofit private entities, to routinely make available tuberculosis services to each individual receiving treatment for substance abuse and to monitor such service delivery.

In FFY2004, the states:

- see Attachment D: Program Compliance Monitoring
- see Attachment E: Tuberculosis (TB) and Early Intervention Services for HIV
- Contracts required programs to make referrals for TB services.

Attachment D: Compliance Monitoring

Notification of Reaching Capacity

The Rhode Island Department of Mental Health, Retardation and Hospitals - Division of Behavioral Health (DBH) notification of reaching capacity includes:

compiling program utilization data in DSA s Client Information System (CIS). The CIS captures active client caseloads in all contract programs. The CIS requires treatment programs to submit admission and discharge data using a unique client identifier on a defined schedule:

- real time for detoxification services,
- **daily** for Narcotic Treatment Programs,
- monthly for outpatient programs, and
- monthly for residential programs

While the CIS is not currently configured to collect and process data for Capacity and Waiting List Management Systems requirements in an automated manner, the currency of the information

and the continuous comparison of each program's current utilization versus capacity provides DBH the means to pro-actively address service issues. Also, capacity is almost always an issue in residential settings where the maximum number of beds is established two ways: one by license and secondly by the facility physical capacity. Capacity is almost never an issue in outpatient settings because there is no capacity established in licensing and physical capacity can be addressed operationally, e.g. through scheduling clinical appointments. Thus the primary area at issue is the residential program settings.

Through contract, providers are required to contact the Department when they reach 90 percent capacity. The prime contractors under the GOP have been instructed to notify the Department whenever the wait for service exceeds 21 calendar days.

Tuberculosis Services

All methadone, residential, and medical detoxification treatment programs are required by licensing regulations to provide a pre-admission physical, which includes necessary laboratory work to include tuberculosis (PPD-Mantoux) testing. In addition, the contracts with treatment programs specify that the program must routinely make available tuberculosis services directly or through arrangements with other entities to all individuals receiving treatment for substance abuse.

Department staff routinely assesses compliance with Federal regulations and state contract and licensing requirements during compliance site visits.

Treatment Services for Pregnant Women

In Rhode Island, all pregnant women under 250 percent of the Federal Poverty Level are covered under the RIte Care Program, the State's approved 1115 Medicaid waiver program. RIte Care covers all primary health care and substance abuse treatment services. Under RIte Care, the Managed Care Operator is able to contract with any provider for the provision of required substance abuse treatment services. As such, services may be provided outside the publicly funded system. The Rhode Island Department of Human Services (DHS), the agency which administers the RIte Care Program, continuously monitors access and utilization of services, and through these processes, is able to insure access to necessary and clinically appropriate services.

Through these continuous and active processes, the DBH and in the case of DHS for substance abuse treatment services for pregnant women, the State of RI has positioned itself to insure access to services and address the requirements under 45 C. F. R. 96.126(c) for intravenous drug services and 45 C. F. R. 96.131(c) for services for pregnant women.

As mentioned in previous sections, the Department routinely assesses compliance with Federal regulations and state contract and licensing requirements as an integral part of its monitoring and compliance site visits.

ATTACHMENT E: TUBERCULOSIS (TB) AND EARLY INTERVENTION SERVICES FOR HIV

FFY2004- Compliance

Due to funding limitations, on-site TB services are not routinely provided at all substance abuse treatment sites. However, all residential and methadone maintenance treatment programs are required, under licensing regulations, to provide, or receive recent documentation of, a pre-admission physical, which includes laboratory work related to tuberculosis (PPD-Mantoux). In addition, all contracted treatment programs receiving Block Grant and/or state funding are contractually obligated to "routinely make available tuberculosis services directly or through arrangements with other public or non-profit entities to all individuals receiving treatment for substance abuse. Services shall include counseling; testing to determine whether the individual has been infected with mycobacteria tuberculosis to determine the appropriate form of treatment, and referral of individuals infected by TB for appropriate medical evaluation and treatment." On-site tuberculosis services are provided at all of CODAC's methadone maintenance sites, in Providence (RI900629), East Providence, Newport, and Wakefield. These programs serve a significant number of clients who are at risk for contracting TB. All programs statewide have access to the state TB clinic located at Roger Williams Hospital in Providence, which is funded by the SSA for public health and communicable diseases (i.e., the Department of Health (DOH)). The Single State Authority for Substance Abuse (i.e., Division of Behavioral Healthcare) regularly confers with staff at the DOH Division of Disease Prevention and Control on TB issues, access, etc., and TB staff have provided consultation to providers on specific areas of concern. Due to funding limitations, no Block Grant funds have specifically been earmarked for TB services. Funding for TB services is derived from the Division of Disease Prevention and Control (DOH DDPC). (Please note that this funding is not limited to TB services for substance abusers, but is available to all Rhode Islanders at high risk for contracting TB.)

During FY04, collaborative training for the state's substance abuse providers was conducted by members of DBH staff and DOH's Division of Disease Prevention and Control (DDPC). This training addressed both prevention and treatment issues related to TB, as well as disseminating information about resources in the state. Rhode Island incorporates its TB training with training related to HIV prevention, early intervention and treatment, harm reduction, Hepatitis A, B & C and STDs, since consumers are at risk for all these diseases, and approaches and resources are related.

Early Intervention Services for HIV were provided at CODAC's methadone maintenance sites in Providence (RI900629), Newport (RI301406), East Bay (RI900975), and Wakefield (CODAC is the state's largest methadone program serving intravenous drug users). All other licensed programs are required to provide or arrange for pre-test and post-test counseling and testing for

HIV for individuals at risk. CODAC as well as other statewide licensed treatment programs collaborate with the Health Department's ENCORE program, which provides HIV outreach, harm reduction and referral for medical and substance abuse treatment services. Technical assistance is provided through ad hoc trainings for individual treatment programs. Additionally, many providers and DBH staff are active in the Department of Health's HIV Community Planning Group (CPG), which annually publishes a Comprehensive Plan for HIV Prevention, which addresses HIV issues related to high risk populations, such as substance abusers, racial and ethnic minorities, youth and other special populations. This group is instrumental in identifying barriers and finding solutions to treatment access, outreach strategies, harm reduction, information dissemination, etc., and serves as a valuable technical assistance mechanism.

DBH staff is active on the Department of Health's Provision of Care (POC) Committee, which meets monthly to address future RFP opportunities as well as estimating and assessing unmet need for HIV positive population. This committee develops the Health Resources and Services Administration (HRSA) annual unmet needs report. Another collaborative initiative between the DBH and DOH is the Injection Drug User (IDU) Task Force. This task force has held focus groups with providers and clients to identify problems and issues around access to services, substance abuse treatment provider training issues, syringe exchange, and the injection drug user population in the prison system. The next step will be for the task force member to create logic models with related strategies to address gaps and create desired outcomes.

FFY2006 - Progress

One recent procedural change was the development of the supportive referral services form by DBH staff. The intent of this new form is for our substance abuse treatment programs to provide clients with referrals for HIV, HCV, TB, and STD testing sites. This was implemented in response to federal guidelines. Also during this time period, additional trainings on HIV, TB, Hepatitis and STDs were provided through a number of mechanisms, including training offered at the New England School of Addiction Studies summer school and school for Best Practices, along with the Project Reach through the Drug and Alcohol Treatment Association. DBH continues to collaborate with the Department of Health on emerging issues related to HIV, TB and other infectious diseases affecting the substance abusing population, and regularly shares information with providers DBH also hosts an ongoing group of providers and staff from the department of Health to keep abreast of new treatments, risks and issues related to substance abuse and infectious diseases, including TB. Information is regularly shared with the treatment network.

The Division of Behavioral Healthcare provided notification to the treatment community on HIV/Behavioral Healthcare specific trainings offered through Project Reach. Documentation of HIV training is required for certification as a chemical dependency professional in the State of Rhode Island.

DBH Substance Abuse Treatment Unit staff met with representative of Project Vista, a program connected with Miriam Hospital, and gave technical assistance on recruitment of participants for HIV early intervention services. Project Vista is based in Providence and coordinates care with Sstar, the state funded medical detoxification provider, and CODAC, the state's largest provider of methadone treatment services. Vista helped to connect eligible individuals with longer-term outpatient methadone withdrawal and maintenance along with providing vital case management services. Participants were connected with emergency shelters and permanent sober housing. Vista also supported psychiatric treatment for participants with co-occurring disorders. The Afia Center is a drop-in center located in downtown Providence which provided case management and education/counseling services to HIV positive and high risk individuals. All individuals are provided with referrals for HIV testing and necessary medical care.

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Recent data has indicated an alarming trend of increased opioid abuse among Rhode Island adolescents. Rhode Island providers have been actively addressing this issue by increasing availability of more intensive treatment services for adolescents in their outpatient programs. One of the state's methadone treatment providers collaborated with a provider of adolescent residential and outpatient services to develop a specialized program for the treatment of adolescent opioid dependence. This approach combined outpatient methadone withdrawal with intensive outpatient services or residential treatment.

DBH staff is active on the Department of Health's Viral Hepatitis Advisory Group (VHAG), which meets monthly. This advisory group has identified needs and gaps of viral hepatitis prevention and treatment services in our state. This group is also has the goal of developing a strategic plan addressing a comprehensive approach to patient care with subcommittees on prevention, service delivery, policy/payer affairs and epidemiology.

- Rhode Island is not a CSAT-designated HIV state.
- Contract required programs to make referrals for TB services.

FFY2007 - Intended

Procedures and activities will be continued as in prior years. Training and information on TB issues continues to be incorporated into courses sponsored by the Drug and Alcohol Treatment

Association (DATA) for Rhode Island's provider network, particularly within existing curriculum addressing HIV/AIDS & Hepatitis C. The provider network then incorporates education, testing and referrals at the program level. Rhode Island will continue to require HIV training as a requirement as certification as a chemical dependency professional.

The Division of Behavioral Healthcare will continue to collaborate and provide technical assistance to innovative early intervention and outreach programs such as Project Vista and MAP outreach.

DBH will assemble a state-wide committee to include other state department and providers to address the increase of our youth abusing opioids. We will continue to analyze data and trends and plan on prevention and intervention strategies.

- According to our project officer, Rhode Island is not a HIV designated state.
- Contract required programs to make referrals for TB services.

In FFY2006, the states continue:

- see Attachment D: Program Compliance Monitoring
- see Attachment E: Tuberculosis (TB) and Early Intervention Services for HIV
- Contracting required programs to make referrals for TB services.

Attachment D: Compliance Monitoring

Notification of Reaching Capacity

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compiling program utilization data in DSA s Client Information System (CIS). The CIS captures active client caseloads in all contract programs. The CIS requires treatment programs to submit admission and discharge data using a unique client identifier on a defined schedule:

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FFY2004- Compliance

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- Rhode Island is not a CSAT-designated HIV state.
- Contract required programs to make referrals for TB services.

FFY2007 - Intended

Procedures and activities will be continued as in prior years. Training and information on TB issues continues to be incorporated into courses sponsored by the Drug and Alcohol Treatment

Association (DATA) for Rhode Island's provider network, particularly within existing curriculum addressing HIV/AIDS & Hepatitis C. The provider network then incorporates education, testing and referrals at the program level. Rhode Island will continue to require HIV training as a requirement as certification as a chemical dependency professional.

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In FFY2007, the state will:

- Continue to require in the contract that sub-contractors routinely make available tuberculosis services directly or through arrangements with other public or non-profit private entities to all individuals receiving treatment for substance abuse.
- see Attachment D: Program Compliance Monitoring
- see Attachment E: Tuberculosis (TB) and Early Intervention Services for HIV

Attachment D: Compliance Monitoring

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ATTACHMENT E: TUBERCULOSIS (TB) AND EARLY INTERVENTION SERVICES FOR HIV

FFY2004- Compliance

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FFY2006 - Progress

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- Rhode Island is not a CSAT-designated HIV state.
- Contract required programs to make referrals for TB services.

FFY2007 - Intended

Procedures and activities will be continued as in prior years. Training and information on TB

issues continues to be incorporated into courses sponsored by the Drug and Alcohol Treatment Association (DATA) for Rhode Island's provider network, particularly within existing curriculum addressing HIV/AIDS & Hepatitis C. The provider network then incorporates education, testing and referrals at the program level. Rhode Island will continue to require HIV training as a requirement as certification as a chemical dependency professional.

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- According to our project officer, Rhode Island is not a HIV designated state.
- Contract required programs to make referrals for TB services.

Rhode Island

Goal #6: HIV Services

GOAL # 6. An agreement, by designated States, to provide treatment for persons with substance abuse problems with an emphasis on making available within existing programs early intervention services for HIV in areas of the State that have the greatest need for such services and to monitor such service delivery (See 42 U.S.C. 300x-24(b) and 45 C.F.R. 96.128).

FY 2004 (Compliance):

FY 2006 (Progress):

FY 2007 (Intended Use):

GOAL # 6

-- An agreement, by designated States, to provide treatment for persons with substance abuse problems with an emphasis on making available within existing programs early intervention services for HIV in areas of the State that have the greatest need for such services and to monitor such service delivery (See 42 U.S.C. 300x-24(b) and 45 C.F.R. 96.128).

FFY 2004 (Compliance):

FFY 2006 (Progress):

FFY 2007 (Intended Use):

FFY 2004
COMPLIANCE REPORT

In FFY2004, the state

- had a provision in the contract with treatment agencies that specified the preference on admission policy;
- monitored sub-contractors' adherence to the required policy during site visits;
- funded specialized AIDS-related services for substance abusers;
- met the HIV set-aside requirement also by using funds to provide methadone maintenance and related services at CODAC II, CODAC III, CODAC IV, and CODAC V (Providence, Newport, East Bay and Wakefield);
- all clients receiving methadone maintenance services were offered on-site early intervention services for HIV, including pre and post-test counseling, testing, referral to primary care physicians for treatment, and extensive coordination with health care and supportive services related to HIV.

Other HIV set-aside activities supported by block grant dollars included support of RI's outpatient and residential drug and alcohol treatment network which serves IVDUs (see Attachment C). Block Grant funds were utilized to provide AIDS-specific training to substance abuse providers and to other professionals in related human service areas. Basic training in HIV, offered through DBH's contractor for training (DATA), remained a requirement for licensure as a chemical dependency professional in the State of Rhode Island.

State & federal funds were re-allocated across the state to improve access to services by redistributing funded slots to Discovery House in Providence, West Warwick, and Woonsocket & Center for Behavioral Health in Johnston and Westerly. CODAC V in Wakefield is funded by DBH and provided the same HIV testing and prevention services as the other CODAC sites. This action was a response to the *"Rhode Island Methadone Treatment Report*" provided by Health & Addiction Research Inc. and funded by CSAT technical assistance initiative.

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- *Pregnant women;*
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- *Persons who while incarcerated began substance abuse treatment and continue to require additional treatment after release from prison;*
- *Treatment Accountability for Safer Communities ("TASC") referred clients;*
- *Adult drug court referrals.*

Also, the Provider will publicize that pregnant women will receive preference in admission for treatment.

FFY 2006
PROGRESS REPORT

In FFY2006, the state

- had a provision in the contract with treatment agencies that specified the preference on admission policy; and

- continued to maintain the following priorities for admission:

    - Pregnant injecting drug users;
    - Pregnant women;
    - Injecting drug users;
    - Persons who are HIV antibody positive or have HIV disease;
    - Parents who are involved with the Department for Children, Youth & Families and are working toward reunification with their children, and whose participation in substance abuse treatment is a prerequisite for reunification;
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DBH created a mandatory HIV/HEP C Supportive Referral Service Form which provides clients with information regarding confidential and anonymous testing sites statewide. Licensing regulations required that all licensed substance abuse agencies review this form with clients and offer a copy which provides contact information. Along with referral for testing, use of this form creates dialogue within the substance abuse program and initiates thinking about HIV infection risk and prevention. Use of this form was monitored by the treatment unit during site visits and licensing reviews.

During site visits, treatment unit monitors assessed compliance with use of the IV/HepC testing referral form. DBH continued to supply forms to providers as requested. Monitors also assessed compliance with provision of case management services as specified in the new outpatient contracts. Failure of treatment agencies to refer to or collaborate with health care providers resulted in agenicies receiving citations and necessitating a plan of correction.

The state-funded medical detoxification program, Sstar of Rhode Island, partnered with Project Vista through Miriam Hospital. Project Vista assisted individuals, primarily IVDUs, access longer-term, outpatient methadone withdrawal or maintenance. Project Vista also established the Afia Center. This drop-in center was designed to provide case management and other services to HIV positive or at-risk individuals. Services provided at the Afia Center inlcude: treatment referrals, support groups, HIV treatment and

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- Prevention and case management for high risk individuals and their partners. Through this program individuals set specific goals to reduce their risk of infection. MAP provided partner notification and encouraged follow through with testing, treatment, and substance abuse treatment.

- Rapid HIV testing. Initially, MAP received funding for only 100 tests yearly, but was able to secure additional testing kits from the Department of Health and Miriam Hospital. Between April 2005 and July 2006, 557 individuals were tested and the program was able to identify three new HIV positive individuals who are all now receiving medical care.

FFY 2007
INTENDED USE REPORT

In FFY2007, the state will

- continue to require in the contract with treatment agencies the provision that specifies the preference on admission policy;
- continue to have state treatment monitors, when conducting site visits, review sub-contractors' adherence to the *above* policy *along with provision of case management services.*
- continue to fund HIV Early Intervention Services, see Form 11, 6A;
- continue to fund specialized AIDS-related services for substance abusers;
- continue to meet HIV set-aside requirement by continuing to fund methadone maintenance services at CODAC II, CODAC III, CODAC IV, and CODAC V (Providence, Newport, East Providence, and Wakefield);

All clients receiving methadone maintenance services will be offered on site early intervention services for HIV, including pre and post-test counseling, testing, referral to primary care physicians for treatment, and extensive coordination with health care and supportive services related to HIV.

Also, the state will continue to meet other set-aside activities by using Block Grant funds to support RI's outpatient and residential drug and alcohol treatment network, along with the state contracted medical detoxification provider, which serves IVDU's; and continue to support collaborative partnerships such as Sstar with Project Vista and MAP Outreach for Rapid HIV Testing.

DBH has collaborated with one of our regional community mental health centers, Northern Rhode Island Mental Health (NRI), in applying for a Robert Woods Johnson Foundation grant to support agressive outreach and aftercare. If approved, this program would expedite re-entry to the treatment system for those at risk of relapse and assistance in securing connections to health care and other needed services.

The state will continue to use Block Grant funds to provide AIDS-specific training to substance abuse providers and to other professionals in related human service areas; continue to require basic HIV training for licensure as a chemical dependency professional; continue to consider re-allocation of funding for methadone treatment across Rhode Island, based on recommendations contained within a CSAT technical assistance-funded report, *"Rhode Island's Methadone Treatment System"*.

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GOAL # 6

-- An agreement, by designated States, to provide treatment for persons with substance abuse problems with an emphasis on making available within existing programs early intervention services for HIV in areas of the State that have the greatest need for such services and to monitor such service delivery (See 42 U.S.C. 300x-24(b) and 45 C.F.R. 96.128).

FFY 2004 (Compliance):

FFY 2006 (Progress):

FFY 2007 (Intended Use):

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FFY 2007
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PROGRESS REPORT

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FFY 2007
INTENDED USE REPORT

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- continue to fund specialized AIDS-related services for substance abusers;
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- Persons who while incarcerated began substance abuse treatment and continue to require additional treatment after release from prison;
- Treatment Accountability for Safer Communities ("TASC") referred clients;
- Adult drug court referrals

Goal #6: HIV Services Footnotes
All clients receiving methadone maintenance services will be offered on site early intervention services for HIV, including pre and post-test counseling, testing, referral to primary care physicians for treatment, and extensive coordination with health care and supportive services related to HIV. Also, the state will continue to meet other set-aside activities by using Block Grant funds to support RI’s outpatient and residential drug and alcohol treatment network, along with the state contracted medical detoxification provider, which serves IVDU’s; and continue to support collaborative partnerships such as Sstar with Project Vista and MAP Outreach for Rapid HIV Testing.

Rhode Island

Attachment E: TB and Early Intervention Svcs

Attachment E: Tuberculosis (TB) and Early Intervention Services for HIV
(See 45 C.F.R. 96.122(f)(1)(x))

For the fiscal year three years prior (FY 2004) to the fiscal year for which the State is applying for funds:

Provide a description of the State's procedures and activities and the total funds expended (or obligated if expenditure data is not available) for tuberculosis services. If a "designated State," provide funds expended (or obligated), for early intervention services for HIV.

Examples of procedures include, but are not limited to:

- development of procedures (and any subsequent amendments), for tuberculosis services and, if a designated State, early intervention services for HIV, e.g., Qualified Services Organization Agreements (QSOA) and Memoranda of Understanding (MOU);
- the role of the single State authority (SSA) for substance abuse prevention and treatment; and
- the role of the single State authority for public health and communicable diseases.

Examples of activities include, but are not limited to:

- the type and amount of training made available to providers to ensure that tuberculosis services are routinely made available to each individual receiving treatment for substance abuse;
- the number and geographic locations (include sub-State planning area) of projects delivering early intervention services for HIV;
- the linkages between IVDU outreach (See 42 U.S.C. 300x-23(b) and 45 C.F.R. 96.126(e)) and the projects delivering early intervention services for HIV; and
- technical assistance.

Attachment E: Tuberculosis (TB) and Early Intervention Services for HIV *(See 45 C.F.R. 96.122(f)(1)(x))*

For the fiscal year three years prior (FFY 2001) to the fiscal year for which the State is applying for funds:

Provide a description of the State's procedures and activities and the total funds expended (or obligated if expenditure data is not available) for tuberculosis services. If a designated State, provide funds expended (or obligated), for early intervention HIV services.

Examples of ***procedures*** *include, but are not limited to:*

__ development of procedures (and any subsequent amendments), for tuberculosis services and, if a designated State, early intervention services for HIV, e.g., Qualified Services Organization Agreements (QSOAs) and Memoranda of Understanding (MOUs);
__ the role of the single State authority (SSA) for substance abuse prevention and treatment; and
__ the role of the single State authority for public health and communicable diseases.

Examples of ***activities*** *include, but are not limited to:*

__ the type and amount of training made available to providers to ensure that tuberculosis services are routinely made available to each individual receiving treatment for substance abuse;
__ the number and geographic location (include substate planning area) of projects delivering early intervention services for HIV;
__ the linkages between IVDU outreach (See 42 U.S.C. 300x-23(b) and C.F.R. 96.126(e)) and the projects delivering early intervention services for HIV; and
__ technical assistance.

ATTACHMENT E: TUBERCULOSIS (TB) AND EARLY INTERVENTION SERVICES FOR HIV

FFY2004- Compliance

Due to funding limitations, on-site TB services are not routinely provided at all substance abuse treatment sites. However, all residential and methadone maintenance treatment programs are required, under licensing regulations, to provide, or receive recent documentation of, a pre-admission physical, which includes laboratory work related to tuberculosis (PPD-Mantoux). In addition, all contracted treatment programs receiving Block Grant and/or state funding are contractually obligated to "routinely make available tuberculosis services directly or through arrangements with other public or non-profit entities to all individuals receiving treatment for substance abuse. Services shall include counseling; testing to determine whether the individual

has been infected with mycobacteria tuberculosis to determine the appropriate form of treatment, and referral of individuals infected by TB for appropriate medical evaluation and treatment." On-site tuberculosis services are provided at all of CODAC's methadone maintenance sites, in Providence (RI900629), East Providence, Newport, and Wakefield. These programs serve a significant number of clients who are at risk for contracting TB. All programs statewide have access to the state TB clinic located at Roger Williams Hospital in Providence, which is funded by the SSA for public health and communicable diseases (i.e., the Department of Health (DOH)). The Single State Authority for Substance Abuse (i.e., Division of Behavioral Healthcare) regularly confers with staff at the DOH Division of Disease Prevention and Control on TB issues, access, etc., and TB staff have provided consultation to providers on specific areas of concern. Due to funding limitations, no Block Grant funds have specifically been earmarked for TB services. Funding for TB services is derived from the Division of Disease Prevention and Control (DOH DDPC). (Please note that this funding is not limited to TB services for substance abusers, but is available to all Rhode Islanders at high risk for contracting TB.)

During FY04, collaborative training for the state's substance abuse providers was conducted by members of DBH staff and DOH's Division of Disease Prevention and Control (DDPC). This training addressed both prevention and treatment issues related to TB, as well as disseminating information about resources in the state. Rhode Island incorporates its TB training with training related to HIV prevention, early intervention and treatment, harm reduction, Hepatitis A, B & C and STDs, since consumers are at risk for all these diseases, and approaches and resources are related.

Early Intervention Services for HIV were provided at CODAC's methadone maintenance sites in Providence (RI900629), Newport (RI301406), East Bay (RI900975), and Wakefield (CODAC is the state's largest methadone program serving intravenous drug users). All other licensed programs are required to provide or arrange for pre-test and post-test counseling and testing for HIV for individuals at risk. CODAC as well as other statewide licensed treatment programs collaborate with the Health Department's ENCORE program, which provides HIV outreach, harm reduction and referral for medical and substance abuse treatment services. Technical assistance is provided through ad hoc trainings for individual treatment programs. Additionally, many providers and DBH staff are active in the Department of Health's HIV Community Planning Group (CPG), which annually publishes a Comprehensive Plan for HIV Prevention, which addresses HIV issues related to high risk populations, such as substance abusers, racial and ethnic minorities, youth and other special populations. This group is instrumental in identifying barriers and finding solutions to treatment access, outreach strategies, harm reduction, information dissemination, etc., and serves as a valuable technical assistance mechanism.

DBH staff is active on the Department of Health's Provision of Care (POC) Committee, which meets monthly to address future RFP opportunities as well as estimating and assessing unmet need for HIV positive population. This committee develops the Health Resources and Services Administration (HRSA) annual unmet needs report. Another collaborative initiative between the DBH and DOH is the Injection Drug User (IDU) Task Force. This task force has held focus

groups with providers and clients to identify problems and issues around access to services, substance abuse treatment provider training issues, syringe exchange, and the injection drug user population in the prison system. The next step will be for the task force member to create logic models with related strategies to address gaps and create desired outcomes.

FFY2006 - Progress

One recent procedural change was the development of the supportive referral services form by DBH staff. The intent of this new form is for our substance abuse treatment programs to provide clients with referrals for HIV, HCV, TB, and STD testing sites. This was implemented in response to federal guidelines. Also during this time period, additional trainings on HIV, TB, Hepatitis and STDs were provided through a number of mechanisms, including training offered at the New England School of Addiction Studies summer school and school for Best Practices, along with the Project Reach through the Drug and Alcohol Treatment Association. DBH continues to collaborate with the Department of Health on emerging issues related to HIV, TB and other infectious diseases affecting the substance abusing population, and regularly shares information with providers DBH also hosts an ongoing group of providers and staff from the department of Health to keep abreast of new treatments, risks and issues related to substance abuse and infectious diseases, including TB. Information is regularly shared with the treatment network.

The Division of Behavioral Healthcare provided notification to the treatment community on HIV/Behavioral Healthcare specific trainings offered through Project Reach. Documentation of HIV training is required for certification as a chemical dependency professional in the State of Rhode Island.

DBH Substance Abuse Treatment Unit staff met with representative of Project Vista, a program connected with Miriam Hospital, and gave technical assistance on recruitment of participants for HIV early intervention services. Project Vista is based in Providence and coordinates care with Sstar, the state funded medical detoxification provider, and CODAC, the state's largest provider of methadone treatment services. Vista helped to connect eligible individuals with longer-term outpatient methadone withdrawal and maintenance along with providing vital case management services. Participants were connected with emergency shelters and permanent sober housing. Vista also supported psychiatric treatment for participants with co-occurring disorders. The Afia Center is a drop-in center located in downtown Providence which provided case management and education/counseling services to HIV positive and high risk individuals. All individuals are provided with referrals for HIV testing and necessary medical care.

MAP, a provider of residential and outpatient substance abuse treatment services, has an active outreach component located in the inner-city neighborhoods of Providence. MAP outreach involves three distinct programs to individuals involved in their substance abuse treatment programs and to others with whom they connect through street outreach. These services include

educational groups with a focus of increasing motivation for treatment engagement, case management services for HIV Positive persons, their partners and others with high-risk behaviors, and rapid HIV testing. DBH collaborated with MAP outreach on several planning committees, along with the Department of Health.

Recent data has indicated an alarming trend of increased opioid abuse among Rhode Island adolescents. Rhode Island providers have been actively addressing this issue by increasing availability of more intensive treatment services for adolescents in their outpatient programs. One of the state's methadone treatment providers collaborated with a provider of adolescent residential and outpatient services to develop a specialized program for the treatment of adolescent opioid dependence. This approach combined outpatient methadone withdrawal with intensive outpatient services or residential treatment.

DBH staff is active on the Department of Health's Viral Hepatitis Advisory Group (VHAG), which meets monthly. This advisory group has identified needs and gaps of viral hepatitis prevention and treatment services in our state. This group is also has the goal of developing a strategic plan addressing a comprehensive approach to patient care with subcommittees on prevention, service delivery, policy/payer affairs and epidemiology.

Rhode Island is not a CSAT-designated HIV state.

FFY2007 - Intended

Procedures and activities will be continued as in prior years. Training and information on TB issues continues to be incorporated into courses sponsored by the Drug and Alcohol Treatment Association (DATA) for Rhode Island's provider network, particularly within existing curriculum addressing HIV/AIDS & Hepatitis C. The provider network then incorporates education, testing and referrals at the program level. Rhode Island will continue to require HIV training as a requirement as certification as a chemical dependency professional.

The Division of Behavioral Healthcare will continue to collaborate and provide technical assistance to innovative early intervention and outreach programs such as Project Vista and MAP outreach.

DBH will assemble a state-wide committee to include other state department and providers to address the increase of our youth abusing opioids. We will continue to analyze data and trends and plan on prevention and intervention strategies.

Rhode Island

Goal #7: Development of Group Homes

GOAL # 7. An agreement to continue to provide for and encourage the development of group homes for recovering substance abusers through the operation of a revolving loan fund (See 42 U.S.C. 300x-25 and 45 C.F.R. 96.129). Effective FY 2001, the States may choose to maintain such a fund. If a State chooses to participate, reporting is required.

FY 2004 (Compliance): (participation OPTIONAL)

FY 2006 (Progress): (participation OPTIONAL)

FY 2007 (Intended Use): (participation OPTIONAL)

GOAL # 7

-- An agreement to continue to provide for and encourage the development of group homes for recovering substance abusers through the operation of a revolving loan fund (See 42 U.S.C. 300x-25 and 45 C.F.R. 96.129).

FFY 2004 (Compliance):

FFY 2006 (Progress):

FFY 2007 (Intended Use):

GOAL # 7. An agreement to continue to provide for and encourage the development of group homes for recovering substance abusers through the operation of a revolving loan fund.

In FFY2004, the state:

- Continued to support the revolving loan program.
- See Attachment F: Group Home Entities.

In FFY2006, the state:

- Continues to support the revolving loan program.
- See Attachment F: Group Home Entities.

In FFY2007, the state will:

- Continue to set-aside funds for continuation of the revolving loan fund.
- Continue close collaboration with the sub-contractor with particular emphasis on outreach, exploration of women's housing and transitional housing.

Attachment F: Group Home Entities

General

For FY 2006, which corresponds to the period July 1, 2005, to June 30, 2006, the State of Rhode Island contracted with the Rhode Island Council on Alcoholism and Other Drug Dependence (RICAODD) to administer the Revolving Loan Program. The State has contracted with RICAODD since July 1, 1993 for the loan fund activities. Duties under the contract include:

1. Managing the loan fund, including authorizing loans and collecting repayments.
2. Developing new homes, including site and finding/recruiting residents.

Fund Balance

On July 1, 2005, the fund balance was $91,7037.19 and on June 30, 2006, the fund balance was $99,779.16.

Loans Issued and Repayments – FY 2005 - 2006

During FFY 2006 three new loans were issued totaling $11,500.00.

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The Council maintained active contact with 10 houses: Concord House, Concord House II, Hilander House, Hope House I, Hope House II, Miracle House, New Foundation House, New Beginnings I, New Beginnings II, and Salvation House.

A total of $1,021.94 in interest was received into the account.

Repayments totaled $17,708.00 for the period.

Source of Funds

The loan fund was initially capitalized with a $100,000 payment by the State to RICAODD in 1993. RICAODD is responsible for maintaining these funds in a distinct checking account. The funds are deposited in an interest bearing, insured account.

In addition to the $100,000 capitalization, the fund accrues:

1) Interest earnings
2) Repayments

Eligible expenses chargeable to the fund are for loans issued in conformance with the purpose of the Revolving Loan Fund.

To improve the information reporting on the Loan Fund status, the Department has implemented, in conjunction with RICAODD, a revised reporting format. This new format better identifies all credit and debit activity in the Loan Fund. The reports on the Loan Fund will be a separate section of the contractually required quarterly program activity report.

Loan Requirements, Application Procedures, and Issues Encountered and Issues Addressed

1) **Loan Requirements**
   a) A minimum of six (6) recovering substance abusers.
   b) Loans must be needed for any legitimate cost associated with the establishment of a recovery house: security deposits, first month's rent purchase of furnishings, minor renovations or repairs, and purchase of essentials which support healthy group living.
   c) The house (residence) must remain substance free.
   d) Any resident who uses any substance will be expelled from the house.
   e) Each resident must have a minimum of 30 days sobriety (some extenuating circumstances apply).
   f) The house will be operated as a self-managed democracy.
   g) The borrowers agree to report monthly on the number of residents entering and leaving the house, and the availability of space for any new residents.
   h) The home shall have in place a system for measuring progress and effectiveness, which will include measures by persons who are not residents of the home.
   i) The home shall maintain a proper accounting of all funds received and repaid.

2) **Application Procedures**
   a) Applicants are encouraged to consider submitting their application in two stages: (1) a pre-application to understand requirements and determined eligibility, and (2) the finial application to secure the loan in an amount sufficient up to a $4,000 limit, to establish the house. The eligibility determination generally takes several days but can be longer if there are any problems with the documentation. Delays can result in the applicant's losing an opportunity on a particular property. Pre-approval allows for better coordination between loan issuance and need.
   b) Application process
      Applications are available at and are processed by:
      RI Council on Alcoholism and Other Drug Dependence
      500 Prospect Street
      Pawtucket, RI 02860
      Telephone: 401-725-0410

3) **Issues Encountered from 2005 - 2006**
   The most prevalent are:
      a) With the current cost of essentials needed to open a new house (security deposits, first month's rent, purchase of furnishings, etc.), it is increasingly difficult to secure them within the $4,000.00 limit.
      b) The rising cost of maintaining present houses (heat, utilities and rents).

c) The need to create and stabilize women's housing. We have converted some of our male houses to co-ed, which seem to be functioning more effectively than all female houses.

Areas to be explored:

a) Identifying areas where no recovery housing is currently available.
b) Continuing to identify more efficient ways to expand and improve the program and to increase capacity.
c) Investigating new and creative ways to help defray the cost of initial setup, including exploring the possibilities of using donations of furniture and household items.

4) **Issues Addressed**

a) Capturing of statistics (relapses, departures due to successful transitions and departures due to misconduct) within our houses has assisted in assessing our effectiveness.
b) Continuing to work closely with landlords, real estate and management companies to facilitate identification of appropriate rental units to open new houses.
c) Increasing grant writing efforts to supplement basic needs of the residents and to enhance the effectiveness of the program.

Contract Agency

As cited previously, the RI Council on Alcoholism and Other Drug Dependence has been the contract agency since July 1, 1993.

Monitoring

The State requires quarterly reports describing program activity, which occurred during the quarter; including but not limited to: (a) homes opened, (b) loan activity, (c) loan fund balance, and (d) overall program issues/activities.

Changes from Prior Years Operations

There have not been any substantial changes to the Program's operations; administration of the fund is unchanged.

GOAL # 7

-- An agreement to continue to provide for and encourage the development of group homes for recovering substance abusers through the operation of a revolving loan fund (See 42 U.S.C. 300x-25 and 45 C.F.R. 96.129).

FFY 2004 (Compliance):

FFY 2006 (Progress):

FFY 2007 (Intended Use):

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In FFY2004, the state:

- Continued to support the revolving loan program.
- See Attachment F: Group Home Entities.

In FFY2006, the state:

- Continues to support the revolving loan program.
- See Attachment F: Group Home Entities.

In FFY2007, the state will:

- Continue to set-aside funds for continuation of the revolving loan fund.
- Continue close collaboration with the sub-contractor with particular emphasis on outreach, exploration of women's housing and transitional housing.

Attachment F: Group Home Entities

General

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Source of Funds

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To improve the information reporting on the Loan Fund status, the Department has implemented, in conjunction with RICAODD, a revised reporting format. This new format better identifies all credit and debit activity in the Loan Fund. The reports on the Loan Fund will be a separate section of the contractually required quarterly program activity report.

Loan Requirements, Application Procedures, and Issues Encountered and Issues Addressed

1) **Loan Requirements**
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   h) The home shall have in place a system for measuring progress and effectiveness, which will include measures by persons who are not residents of the home.
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2) **Application Procedures**
   a) Applicants are encouraged to consider submitting their application in two stages: (1) a pre-application to understand requirements and determined eligibility, and (2) the finial application to secure the loan in an amount sufficient up to a $4,000 limit, to establish the house. The eligibility determination generally takes several days but can be longer if there are any problems with the documentation. Delays can result in the applicant's losing an opportunity on a particular property. Pre-approval allows for better coordination between loan issuance and need.
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3) **Issues Encountered from 2005 - 2006**
   The most prevalent are:
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Eligible expenses chargeable to the fund are for loans issued in conformance with the purpose of the Revolving Loan Fund.

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Areas to be explored:

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4) **Issues Addressed**

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Changes from Prior Years Operations

There have not been any substantial changes to the Program's operations; administration of the fund is unchanged.

Rhode Island

Attachment F: Group Home Entities

Attachment F: Group Home Entities and Programs
(See 42 U.S.C. 300x-25; 45 C.F.R. 96.129; and 45 C.F.R. 96.122(f)(1)(vii))

If the State has chosen in Fiscal Year 2004 to participate and continue to provide for and encourage the development of group homes for recovering substance abusers through the operation of a revolving loan fund then Attachment F must be completed.

Provide a list of all entities that have received loans from the revolving fund during FY 2004 to establish group homes for recovering substance abusers. In a narrative of up to two pages, describe the following:

- the number and amount of loans made available during the applicable fiscal years;
- the amount available in the fund throughout the fiscal year;
- the source of funds used to establish and maintain the revolving fund;
- the loan requirements, application procedures, the number of loans made, the number of repayments, and any repayment problems encountered;
- the private, nonprofit entity selected to manage the fund;
- any written agreement that may exist between the State and the managing entity;
- how the State monitors fund and loan operations; and
- any changes from previous years' operations.

Attachment F: Group Home Entities

General

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Changes from Prior Years Operations

There have not been any substantial changes to the Program's operations; administration of the fund is unchanged.

Rhode Island

Goal #8: Tobacco Products

GOAL # 8. An agreement to continue to have in effect a State law that makes it unlawful for any manufacturer, retailer, or distributor of tobacco products to sell or distribute any such product to any individual under the age of 18; and, to enforce such laws in a manner that can reasonably be expected to reduce the extent to which tobacco products are available to individuals under age 18 (See 42 U.S.C. 300x-26 and 45 C.F.R. 96.130).

- Is the State's FY 2007 Annual Synar Report included with the FY 2007 uniform application?
  Yes No
- If No, please indicate when the State plans to submit the report:
  mm/dd/2006

Note: The statutory due date is December 31, 2006.

GOAL # 8

-- An agreement to continue to have in effect a State law that makes it unlawful for any manufacturer, retailer, or distributor of tobacco products to sell or distribute any such product to any individual under the age of 18; and, to enforce such laws in a manner that can reasonably be expected to reduce the extent to which tobacco products are available to individuals under age 18 (See 42 U.S.C. 300x-26 and 45 C.F.R. 96.130).

FFY 2004 (Compliance Progress):

FFY 2006 (Intended Use):

FFY 2007 (Progress):

GOAL # 8. An agreement to continue to have in effect a State law that makes it unlawful for any manufacturer, retailer, or distributor of tobacco products to sell or distribute any such product to any individual under the age of 18; and, to enforce such law in a manner that can reasonably be expected to reduce the extent to which tobacco products are available to individuals under age 18.

The SYNAR Report is not included in this application and will be submitted by 12/30/2006.

Rhode Island

Goal #9: Pregnant Women Preferences

GOAL # 9. An agreement to ensure that each pregnant woman be given preference in admission to treatment facilities; and, when the facility has insufficient capacity, to ensure that the pregnant woman be referred to the State, which will refer the woman to a facility that does have capacity to admit the woman, or if no such facility has the capacity to admit the woman, will make available interim services within 48 hours, including a referral for prenatal care (See 42 U.S.C. 300x-27 and 45 C.F.R. 96.131).

FY 2004 (Compliance):

FY 2006 (Progress):

FY 2007 (Intended Use):

GOAL # 9

-- An agreement to ensure that each pregnant woman be given preference in admission to treatment facilities; and, when the facility has insufficient capacity, to ensure that the pregnant woman be referred to the State, which will refer the woman to a facility that does have capacity to admit the woman, or if no such facility has the capacity to admit the woman, will make available interim services within 48 hours, including a referral for prenatal care (See 42 U.S.C. 300x-27 and 45 C.F.R. 96.131).

FFY 2004 (Compliance):

FFY 2006 (Progress):

FFY 2007 (Intended Use):

GOAL # 9. An agreement to ensure that each pregnant woman be given preference in admission to treatment and, when the facility has insufficient capacity, to ensure that the pregnant women be referred to the State, which will refer the woman to a facility that does have capacity to admit the woman, or if no such facility has the capacity to admit the woman, will make available interim services within 48 hours, including a referral for prenatal care.

In FFY2004, the state:

- had a provision in the contract with treatment agencies that specified the preference on admission policy;
- the state produced signs describing the admission preference policy. These were distributed to all sub-contractors for posting. These signs were produced by the department of MHRH and distributed to all subcontractors for posting.
- When conducting site visits the Treatment Unit monitored and reviewed sub-contractors' adherence to the required policy; through its 1115 managed care program, RIte Care, emphasizes substance abuse services as part of primary health care.
- All state agencies were required to publicly post signage describing the admission preference policy admission preference policy.

(Contract Specifications): *Admission into state funded treatment will be prioritized in the following descending:*

- *Pregnant injecting drug users;*
- *Pregnant women;*
- *Injecting drug users;*
- *Persons who are HIV antibody positive or have HIV disease;*
- *Parents who are involved with the Department for Children, Youth*

& Families and are working toward reunification with their children, and whose participation in substance abuse treatment is a prerequisite for reunification;
- *Persons who while incarcerated began substance abuse treatment and continue to require additional treatment after release from prison;*
- *Treatment Accountability for Safer Communities ("TASC") referred clients;*
- *Adult drug court referrals.*

Also, the Provider will publicize that pregnant women will receive preference in admission for treatment.

In FFY2006, the state:
- Continues to require in the contract with treatment agencies that specifies the preference on admission policy;
- Continues to require all state agencies are to publicly post signage describing the admission preference policy admission preference policy; which the state distributed to all sub-contractors for posting;
- The Treatment team continues to act as a referral agent for appropriate placement of pregnant women.

(Contract Specifications): Admission into state funded treatment will be prioritized in the following descending:
- *Pregnant injecting drug users;*
- *Pregnant women;*
- *Injecting drug users;*
- *Persons who are HIV antibody positive or have HIV disease;*
- *Parents who are involved with the Department for Children, Youth & Families and are working toward reunification with their children, and whose participation in substance abuse treatment is a prerequisite for reunification;*
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- *Adult drug court referrals.*

Also, the Provider will publicize that pregnant women will receive preference in admission for treatment.

When conducting site visits the DBH Treatment Team continues to monitor and review the sub-contractors' adherence to the required policy; through its 1115 managed care program, RIte Care, emphasizes substance abuse services as part of primary health care.

In FFY2007, the state will:

- Continue to require in the contract with treatment agencies that specifies the preference on admission policy;
- Continue to require all state agencies are to publicly post signage describing the admission preference policy admission preference policy; which the state distributed to all sub-contractors for posting;
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When conducting site visits the DBH Treatment Team will continue to monitor and review the sub-contractors' adherence to the required policy; through its 1115 managed care program, RIte Care, emphasizes substance abuse services as part of primary health care.

GOAL # 9

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FFY 2004 (Compliance):

FFY 2006 (Progress):

FFY 2007 (Intended Use):

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FFY 2004 (Compliance):

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When conducting site visits the DBH Treatment Team continues to monitor and review the sub-contractors' adherence to the required policy; through its 1115 managed care program, RIte Care, emphasizes substance abuse services as part of primary health care.

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- Continue to require in the contract with treatment agencies that specifies the preference on admission policy;
- Continue to require all state agencies are to publicly post signage describing the admission preference policy admission preference policy; which the state distributed to all sub-contractors for posting;
- The Treatment team will continue to act as a referral agent for appropriate placement of pregnant women.

(Contract Specifications): Admission into state funded treatment will be prioritized in the following descending:

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When conducting site visits the DBH Treatment Team will continue to monitor and review the sub-contractors' adherence to the required policy; through its 1115 managed care program, RIte Care, emphasizes substance abuse services as part of primary health care.

Rhode Island

Attachment G: Capacity Management

Attachment G: Capacity Management and Waiting List Systems
(See 45 C.F.R. 96.122(f)(3)(vi))

For the fiscal year two years prior (FY 2005) to the fiscal year for which the State is applying for funds:

In up to five pages, provide a description of the State's procedures and activities undertaken, and the total amount of funds expended (or obligated if expenditure data is not available), to comply with the requirement to develop capacity management and waiting list systems for intravenous drug users and pregnant women (See 45 C.F.R. 96.126(c) and 45 C.F.R. 96.131(c), respectively). This report should include information regarding the utilization of these systems. Examples of procedures may include, but not be limited to:

- development of procedures (and any subsequent amendments) to reasonably implement a capacity management and waiting list system;
- the role of the Single State Authority (SSA) for substance abuse prevention and treatment;
- the role of intermediaries (county or regional entity), if applicable, and substance abuse treatment providers; and
- the use of technology, e.g., toll-free telephone numbers, automated reporting systems, etc.

Examples of activities may include, but not be limited to:

- how interim services are made available to individuals awaiting admission to treatment;
- the mechanism(s) utilized by programs for maintaining contact with individuals awaiting admission to treatment; and
- technical assistance.

Attachment H: Capacity Management and Waiting List Systems *(See 45 C.F.R. 96.122(f)(3)(vi))*

For the fiscal year two years prior (FFY 2001) to the fiscal year for which the State is applying for funds:

*In **up to five pages** provide a description of the State's procedures and activities undertaken, and the total amount of funds expended (or obligated if expenditure data is not available), to comply with the requirements to develop capacity management and waiting list systems for intravenous drug users and pregnant women (See 45 C.F.R. 96.126(c) and 45 C.F.R. 96.131(c) respectively). This report should include information regarding the utilization of these systems.*

*Examples of **procedures** may include, but not be limited to:*

__ development of procedures (and any subsequent amendments) to reasonably implement a capacity management and waiting list system;
__ the role of the single State authority (SSA) for substance abuse prevention and treatment;
__ the role of intermediaries (county or regional entity), if applicable, and substance abuse treatment providers; and
__ the use of technology, e.g., toll-free telephone numbers, automated reporting systems, etc..

*Examples of **activities** may include, but not be limited to:*

__ how interim services are made available to individuals awaiting admission to treatment;
__ the mechanism(s) utilized by programs for maintaining contact with individuals awaiting admission to treatment
__ technical assistance

Attachment G: Capacity Management & Waiting List Systems

The Rhode Island Department of Mental Health, Retardation and Hospitals - Division of Behavioral Healthcare Services has undertaken the following steps regarding Capacity Management and Waiting List Systems:

- maintaining and ongoing monitoring of utilization data in DBH's Client InformationSystem (CIS). The CIS collects active client caseload information from all contract programs using a unique client identifier - three initials and last four digits of social security - for all admissions and discharges. DBH has implemented a revised, accelerated schedule on submitting utilization data. The schedule which follows, has enhanced our oversight of utilization system-wide and by program by assuring that the data is current:

- real time for detoxification services,
- **daily** for Narcotic Treatment Programs,
- monthly for outpatient programs, and
- monthly for residential programs

While the CIS is not currently specifically set-up to collect and process data to meet Capacity and Waiting List Management Systems needs in an automated manner, the currency of the information and the continuous comparison of each programs current utilization versus capacity provides DBH the means to pro-actively address service issues. Also, capacity is almost always an issue in residential settings where the maximum number of beds is established two ways: one by license and secondly by the facility=s physical capacity. Capacity is almost never an issue in outpatient settings because there is no capacity established in licensing and physical capacity can be addressed operationally, e.g. through scheduling/staggering clinical appointments. Thus the primary area at issue is the residential program settings.

The State has a single contractor for statewide detoxification services. The contract, a global capitated at-risk, specifies that detoxification services must be provided on demand. For contract monitoring purposes, this means that a client must be admitted within 48 hours of requesting service.

The DBH functions as the central registry for all methadone programs licensed in the State. Through this activity, DBH is in almost daily contact with narcotic treatment programs. As a component of this clearing process, the methadone programs must be contact with each other. This further insures that clients requesting admission into an IVDU program is handled in the most expeditious manner.

Contract language, which specifies admission preference - in addition to the Block Grant priority populations requirements, specifies other additional populations and financial eligibility, which insures the most needy are served. The contract also requires the provision of interim services when the program reaches capacity and cannot be admitted, and the maintenance of a waiting list, identifying each client by the unique client identifier.

By conducting onsite Program Monitoring and regular meetings with drug-free treatment programs, the DBH has continuous information on the relationship of capacity to demand in each program. Through the regular meetings, DBH is able to prospectively ascertain when programs are approaching 90.0 percent of capacity. Also, during the onsite monitoring visit the review ascertains whether the program complied with contract requirements identified above.

As only residential programs generally have a defined finite capacity, the inability to admit clients requesting treatment are limited to this service category, and DBH maintains ongoing communications and oversight of utilization through the CIS and contacts with the agencies. Pregnant women may be placed on a waiting list for Sstarbirth, our contract residential treatment provider for pregnant and post-partum women. Upon assessment, women are referred to other residential treatment programs for interim services and are prioritized for admission. All levels of

outpatient treatment may be utilized as interim services for women who are awaiting placement at Sstarbirth.

Contract language for the new GOP system specifies that if the Provider's static capacity is over subscribed, a wait list for services may be established. However, before a client is wait listed for a service, the Provider will determine if there exists capacity at another Department Provider in a region the client could travel to. Static and dynamic capacity is reviewed on a monthly basis for the each of the GOP prime contractors. Prime Contractors are also required to complete quarterly reports to the Department of MHRH, Division of Behavioral Healthcare outlining the number of weekly assessments, admissions, discharges and census data along with frequency of clinical services.

In Rhode Island, for all practical purposes all pregnant women are covered for substance abuse services outside of the publicly funded substance abuse system. Specifically, while the income limit for indigent services is 200 percent of the Federal Poverty Level, other public and private initiatives cover pregnant women in effect provide universal coverage:

- pregnant and women with children with income under 250 percent of the Federal Poverty Level are covered under the RIte Care Program, this State=s approved 1115 Medicaid waiver program. Under RIte Care all substance abuse treatment services are in-plan.

- pregnant women in households between 251 and 350 percent of the Federal Poverty Level are eligible for RIte Care Program during the period of the pregnancy. Under this situation, the women are eligible for the same array of services as the first group, to include a full range of substance abuse treatment services.

Under RIte Care, the Managed Care Operator is able to contract with any provider for the provision of required substance abuse treatment services. As such, services may be provided in programs not part of the publicly funded system. The Rhode Island Department of Human Services (DHS), the agency which administers the RIte Care Program, continuously monitors access and utilization of services, and through these processes, is able to insure access to necessary and clinically appropriate services.

Although pregnant women are receiving required substance abuse treatment services under other auspices, when conducting on-site monitoring, DBH's monitors confirm the preferential admission policy, and the treatment agency's policy(ies) and practices on maintaining contact and providing interim services to applicants awaiting admission into treatment. Further, through a review of case records, DBH is able to affirm that these requirements are fully met.

Through these continuous and active processes, the DBH and in the case of DHS for substance abuse treatment services for pregnant women, the State of RI has implemented steps to address interim services needs and services to pregnant women as prescribed under 45 C. F. R. 96.126(c) for intravenous drug services and 45 C. F. R. 96.131(c) for services for pregnant women.

Rhode Island

Goal #10: Process for Referring

GOAL # 10. An agreement to improve the process in the State for referring individuals to the treatment modality that is most appropriate for the individual (See 42 U.S.C. 300x-28(a) and 45 C.F.R. 96.132(a)).

FY 2004 (Compliance):

FY 2006 (Progress):

FY 2007 (Intended Use):

GOAL # 10

-- An agreement to improve the process in the State for referring individuals to the treatment modality that is most appropriate for the individual (See 42 U.S.C. 300x-28(a) and 45 C.F.R. 96.132(a)).

FFY 2004 (Compliance):

FFY 2006 (Progress):

FFY 2007 (Intended Use):

GOAL # 10. An agreement to improve the process in the State for referring individuals to the treatment modality that is most appropriate for the individual.

In FFY2004, the state:

- Re- procured the General Outpatient (GOP) system of care by having a Request for Proposal (RFP) in which the applicants submitted proposals. This GOP system has been collapsed into five treatment zones, one for each region within the state. Each of the five have a lead contractor who has collaborated with several smaller partners. This process allowed our state to look at the needs of the clients and identify improved strategies to respond to these needs.
- see Attachment G: Capacity Management and Waiting List Systems
- Continued use of ASAM-PPC-2 for all treatment programs in the state

Attachment G: Capacity Management & Waiting List Systems

The Rhode Island Department of Mental Health, Retardation and Hospitals - Division of Behavioral Healthcare Services has undertaken the following steps regarding Capacity Management and Waiting List Systems:

- maintaining and ongoing monitoring of utilization data in DBH's Client InformationSystem (CIS). The CIS collects active client caseload information from all contract programs using a unique client identifier - three initials and last four digits of social security - for all admissions and discharges. DBH has implemented a revised, accelerated schedule on submitting utilization data. The schedule which follows, has enhanced our oversight of utilization system-wide and by program by assuring that the data is current:

- real time for detoxification services,
- **daily** for Narcotic Treatment Programs,
- monthly for outpatient programs, and
- monthly for residential programs

While the CIS is not currently specifically set-up to collect and process data to meet Capacity and Waiting List Management Systems needs in an automated manner, the currency of the information and the continuous comparison of each programs current utilization versus capacity provides DBH the means to pro-actively address service issues. Also, capacity is almost always an issue in residential settings where the maximum number of beds is established two ways: one by license and secondly by the facility=s physical capacity. Capacity is almost never an issue in outpatient settings because there is no capacity established in licensing and physical capacity can be addressed operationally, e.g. through scheduling/staggering clinical appointments. Thus the primary area at issue is the residential program settings.

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The DBH functions as the central registry for all methadone programs licensed in the State. Through this activity, DBH is in almost daily contact with narcotic treatment programs. As a component of this clearing process, the methadone programs must be contact with each other. This further insures that clients requesting admission into an IVDU program is handled in the most expeditious manner.

Contract language, which specifies admission preference - in addition to the Block Grant priority populations requirements, specifies other additional populations and financial eligibility, which insures the most needy are served. The contract also requires the provision of interim services when the program reaches capacity and cannot be admitted, and the maintenance of a waiting list, identifying each client by the unique client identifier.

By conducting onsite Program Monitoring and regular meetings with drug-free treatment programs, the DBH has continuous information on the relationship of capacity to demand in each program. Through the regular meetings, DBH is able to prospectively ascertain when programs are approaching 90.0 percent of capacity. Also, during the onsite monitoring visit the review ascertains whether the program complied with contract requirements identified above.

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residential treatment programs for interim services and are prioritized for admission. All levels of outpatient treatment may be utilized as interim services for women who are awaiting placement at Sstarbirth.

Contract language for the new GOP system specifies that if the Provider's static capacity is over subscribed, a wait list for services may be established. However, before a client is wait listed for a service, the Provider will determine if there exists capacity at another Department Provider in a region the client could travel to. Static and dynamic capacity is reviewed on a monthly basis for the each of the GOP prime contractors. Prime Contractors are also required to complete quarterly reports to the Department of MHRH, Division of Behavioral Healthcare outlining the number of weekly assessments, admissions, discharges and census data along with frequency of clinical services.

In Rhode Island, for all practical purposes all pregnant women are covered for substance abuse services outside of the publicly funded substance abuse system. Specifically, while the income limit for indigent services is 200 percent of the Federal Poverty Level, other public and private initiatives cover pregnant women in effect provide universal coverage:

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In FFY2006, the state:

- Continued to require use of ASAM-PPC-current edition in all treatment contracts.
- Continued to utilize needs assessment data to determine whether current substance abuse treatment services are adequate in their amount; are located where they are needed; and whether the service mix reflects the clinical needs of the population that would seek services if they were available.
- Continued the management of treatment programs as described in Attachment G.

Attachment G: Capacity Management & Waiting List Systems

The Rhode Island Department of Mental Health, Retardation and Hospitals - Division of Behavioral Healthcare Services has undertaken the following steps regarding Capacity Management and Waiting List Systems:

- maintaining and ongoing monitoring of utilization data in DBH's Client InformationSystem (CIS). The CIS collects active client caseload information from all contract programs using a unique client identifier - three initials and last four digits of social security - for all admissions and discharges. DBH has implemented a revised, accelerated schedule on submitting utilization data. The schedule which follows, has enhanced our oversight of utilization system-wide and by program by assuring that the data is current:

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In FFY2006, the state:

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GOAL # 10

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- pregnant and women with children with income under 250 percent of the Federal Poverty Level are covered under the RIte Care Program, this State=s approved 1115 Medicaid waiver program. Under RIte Care all substance abuse treatment services are in-plan.

- pregnant women in households between 251 and 350 percent of the Federal Poverty Level are eligible for RIte Care Program during the period of the pregnancy. Under this situation, the women are eligible for the same array of services as the first group, to include a full range of substance abuse treatment services.

Under RIte Care, the Managed Care Operator is able to contract with any provider for the provision of required substance abuse treatment services. As such, services may be provided in programs not part of the publicly funded system. The Rhode Island Department of Human Services (DHS), the agency which administers the RIte Care Program, continuously monitors access and utilization of services, and through these processes, is able to insure access to necessary and clinically appropriate services.

Although pregnant women are receiving required substance abuse treatment services under other auspices, when conducting on-site monitoring, DBH's monitors confirm the preferential admission policy, and the treatment agency's policy(ies) and practices on maintaining contact and providing interim services to applicants awaiting admission into treatment. Further, through a review of case records, DBH is able to affirm that these requirements are fully met.

Through these continuous and active processes, the DBH and in the case of DHS for substance abuse treatment services for pregnant women, the State of RI has implemented steps to address interim services needs and services to pregnant women as prescribed under 45 C. F. R. 96.126(c) for intravenous drug services and 45 C. F. R. 96.131(c) for services for pregnant women.

In FFY2006, the state:

- Continued to require use of ASAM-PPC-current edition in all treatment contracts.
- Continued to utilize needs assessment data to determine whether current substance abuse treatment services are adequate in their amount; are located where they are needed; and whether the service mix reflects the clinical needs of the population that would seek services if they were available.
- Continued the management of treatment programs as described in Attachment G.

Attachment G: Capacity Management & Waiting List Systems

The Rhode Island Department of Mental Health, Retardation and Hospitals - Division of Behavioral Healthcare Services has undertaken the following steps regarding Capacity Management and Waiting List Systems:

- maintaining and ongoing monitoring of utilization data in DBH's Client InformationSystem (CIS). The CIS collects active client caseload information from all contract programs using a unique client identifier - three initials and last four digits of social security - for all admissions and discharges. DBH has implemented a revised, accelerated schedule on submitting utilization data. The schedule which follows, has enhanced our oversight of utilization system-wide and by program by assuring that the data is current:

    - real time for detoxification services,
    - **daily** for Narcotic Treatment Programs,
    - monthly for outpatient programs, and
    - monthly for residential programs

While the CIS is not currently specifically set-up to collect and process data to meet Capacity and Waiting List Management Systems needs in an automated manner, the currency of the information and the continuous comparison of each programs current utilization versus capacity provides DBH the means to pro-actively address service issues. Also, capacity is almost always an issue in residential settings where the maximum number of beds is established two ways: one by license and secondly by the facility=s physical capacity. Capacity is almost never an issue in outpatient settings because there is no capacity established in licensing and physical capacity can be addressed operationally, e.g. through scheduling/staggering clinical appointments. Thus the primary area at issue is the residential program settings.

The State has a single contractor for statewide detoxification services. The contract, a global capitated at-risk, specifies that detoxification services must be provided on demand. For contract monitoring purposes, this means that a client must be admitted within 48 hours of requesting service.

The DBH functions as the central registry for all methadone programs licensed in the State. Through this activity, DBH is in almost daily contact with narcotic treatment programs. As a component of this clearing process, the methadone programs must be contact with each other. This further insures that clients requesting admission into an IVDU program is handled in the most expeditious manner.

Contract language, which specifies admission preference - in addition to the Block Grant priority populations requirements, specifies other additional populations and financial eligibility, which insures the most needy are served. The contract also requires the provision of interim services when the program reaches capacity and cannot be admitted, and the maintenance of a waiting list, identifying each client by the unique client identifier.

By conducting onsite Program Monitoring and regular meetings with drug-free treatment programs, the DBH has continuous information on the relationship of capacity to demand in each program. Through the regular meetings, DBH is able to prospectively ascertain when programs are approaching 90.0 percent of capacity. Also, during the onsite monitoring visit the review ascertains whether the program complied with contract requirements identified above.

As only residential programs generally have a defined finite capacity, the inability to admit clients requesting treatment are limited to this service category, and DBH maintains ongoing communications and oversight of utilization through the CIS and contacts with the agencies. Pregnant women may be placed on a waiting list for Sstarbirth, our contract residential treatment provider for pregnant and post-partum women. Upon assessment, women are referred to other residential treatment programs for interim services and are prioritized for admission. All levels of outpatient treatment may be utilized as interim services for women who are awaiting placement at Sstarbirth.

Contract language for the new GOP system specifies that if the Provider's static capacity is over subscribed, a wait list for services may be established. However, before a client is wait listed for a service, the Provider will determine if there exists capacity at another Department Provider in a region the client could travel to. Static and dynamic capacity is reviewed on a monthly basis for the each of the GOP prime contractors. Prime Contractors are also required to complete quarterly reports to the Department of MHRH, Division of Behavioral Healthcare outlining the number of weekly assessments, admissions, discharges and census data along with frequency of clinical services.

In Rhode Island, for all practical purposes all pregnant women are covered for substance abuse services outside of the publicly funded substance abuse system. Specifically, while the income limit for indigent services is 200 percent of the Federal Poverty Level, other public and private initiatives cover pregnant women in effect provide universal coverage:

- pregnant and women with children with income under 250 percent of the Federal Poverty Level are covered under the RIte Care Program, this State=s approved 1115 Medicaid waiver program. Under RIte Care all substance abuse treatment services are in-plan.

- pregnant women in households between 251 and 350 percent of the Federal Poverty Level are eligible for RIte Care Program during the period of the pregnancy. Under this situation, the women are eligible for the same array of services as the first group, to include a full range of substance abuse treatment services.

Under RIte Care, the Managed Care Operator is able to contract with any provider for the provision of required substance abuse treatment services. As such, services may be provided in programs not part of the publicly funded system. The Rhode Island Department of Human Services (DHS), the agency which administers the RIte Care Program, continuously monitors access and utilization of services, and through these processes, is able to insure access to necessary and clinically appropriate services.

Although pregnant women are receiving required substance abuse treatment services under other auspices, when conducting on-site monitoring, DBH's monitors confirm the preferential admission policy, and the treatment agency's policy(ies) and practices on maintaining contact and providing interim services to applicants awaiting admission into treatment. Further, through a review of case records, DBH is able to affirm that these requirements are fully met.

Through these continuous and active processes, the DBH and in the case of DHS for substance abuse treatment services for pregnant women, the State of RI has implemented steps to address interim services needs and services to pregnant women as prescribed under 45 C. F. R. 96.126(c) for intravenous drug services and 45 C. F. R. 96.131(c) for services for pregnant women.

In FFY2007, the state will:

- Continue to require use of ASAM-PPC-current edition in all treatment contracts.
- Continue to utilize needs assessment data to determine whether current substance abuse treatment services are adequate in their amount; are located where they are needed; and whether the service mix reflects the clinical needs of the population that would seek services if they were available.
- Continue the management of treatment programs as described in Attachment G.

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While the CIS is not currently specifically set-up to collect and process data to meet Capacity and Waiting List Management Systems needs in an automated manner, the currency of the information and the continuous comparison of each programs current utilization versus capacity provides DBH the means to pro-actively address service issues. Also, capacity is almost always an issue in residential settings where the maximum number of beds is established two ways: one by license and secondly by the facility=s physical capacity. Capacity is almost never an issue in outpatient settings because there is no capacity established in licensing and physical capacity can be addressed operationally, e.g. through scheduling/staggering clinical appointments. Thus the primary area at issue is the residential program settings.

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As only residential programs generally have a defined finite capacity, the inability to admit clients requesting treatment are limited to this service category, and DBH maintains ongoing communications and oversight of utilization through the CIS and contacts with the agencies. Pregnant women may be placed on a waiting list for Sstarbirth, our contract residential treatment provider for pregnant and post-partum women. Upon assessment, women are referred to other residential treatment programs for interim services and are prioritized for admission. All levels of outpatient treatment may be utilized as interim services for women who are awaiting placement at Sstarbirth.

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Rhode Island

Goal #11: Continuing Education

GOAL # 11. An agreement to provide continuing education for the employees of facilities which provide prevention activities or treatment services (or both as the case may be) (See 42 U.S.C. 300x-28(b) and 45 C.F.R. 96.132(b)).

FY 2004 (Compliance):

FY 2006 (Progress):

FY 2007 (Intended Use):

GOAL #11

-- An agreement to provide continuing education for the employees of facilities which provide prevention activities and treatment services (See 42 U.S.C. 300x-28(b) and 45 C.F.R. 96.132(b)).

FFY 2004
COMPLIANCE REPORT

The State of Rhode Island, through the Department of Mental Health, Retardation and Hospitals, the Department, develops, implements and coordinates a comprehensive continuing education program for employees and volunteers of facilities and other organizations providing prevention and treatment services.

There are five primary components of Rhode Island's substance abuse training and education system: an ICRC-recognized certification process, on-going workshops and trainings provided through a contract with a statewide training and advocacy association, conferences and institutes provided by the New England School of Addiction Studies, and training and technical assistance provided to State Incentive Grant sub-recipients through the Northeast Center for the Application of prevention Technology (NECAPT). Other training and technical assistance is provided on an ad hoc basis either by the Department or in collaboration with other federal, State or community organizations.

All Department contracts with organizations providing prevention, treatment or student assistance services included a provision requiring the contracting entity to provide continuing education for their employees and to participate in any training mandated by the Department during the contract period.

PREVENTION AND TREATMENT

Rhode Island Board for the Certification of Chemical Dependency Professionals (RIBCCDP)

In FFY 2004, the Department provided funding through the SAPT Block Grant to the RI Board for the Certification of Chemical Dependency Professionals (RIBCCDP), which oversees the certification process for treatment, prevention, and student assistance professionals. The Board also provides technical assistance to the Rhode Island College Chemical Dependency/Alcohol Studies Program. The Department is represented on the RIBCCDP Advisory Committee.

Drug and Alcohol Treatment Association of Rhode Island (DATA)

In FFY 2004, the Department contracted with DATA to oversee the statewide training and continuing education program for substance abuse and allied professionals. DATA provided training to employees and volunteer staff of agencies and organizations engaged in substance abuse prevention, treatment and student assistance services as well as to staff of other State agencies and CBOs providing related services. The Department also contracted with DATA to operate "In-Rhodes" the State's resource center for substance abuse, HIV/AIDS, STD, suicide prevention and violence prevention. In-Rhodes is designated as the State's RADAR Network Center.

New England Institute of Addiction Studies

The Department is a member of the six-state New England Institute of Addiction Studies (NEIAS) and is represented on the Board of Directors Training Development Committee and an ad-hoc conference/workshop planning committee.

During FFY 2004, the Department co-sponsored and/or participated in the planning, coordination and implementation of the following institutes, conferences and workshops:

- The 38th annual New England School of Addiction Studies
- The 14th annual New England School of Best Practices in Addiction Treatment (formerly known as the Advanced School of Addiction Studies)
- The 4th annual New England School of Prevention Studies

During FFY 2004, the Department offered scholarships to employees and volunteers of Department-funded agencies and organizations as well as to other State departments and agencies such as the Departments of Health; Children, Youth and Families; and Corrections to attend workshops and training sessions to promote awareness of substance abuse related issues, to improve the knowledge base and to increase collaboration in order to improve prevention and treatment services statewide.

PREVENTION

In FFY 2004 the Department collaborated with the NECAPT, DATA, the Safe and Drug Free Schools Coordinator and other sister state agencies to conduct training and technical assistance initiatives to implement evidence-based programs. The Department coordinated provision of training and technical assistance to substance abuse prevention providers funded by SAPT Block Grant, Governor's Portion/Safe & Drug Free Schools and Communities, and State Incentive Grant sub-recipients. In FFY 2004 the Department collaborated with DATA to provide training on CSAP Model, Promising and Effective Programs to SIG recipients. The Department maximized "model program" training opportunities for RI communities by providing spaces in SIG sub-recipient trainings for CSAP's science-based programs

In FFY 2004 the Department provided orientation sessions to all SIG sub-recipients on the Sub-Recipient Checklist and data requirements of the SIG National Cross Site Evaluation.

GOAL #11

-- An agreement to provide continuing education for the employees of facilities which provide prevention activities and treatment services (See 42 U.S.C. 300x-28(b) and 45 C.F.R. 96.132(b)).

FFY 2006
PROGRESS REPORT

In FFY 2006, the Department continues to develop, implement, and coordinate a comprehensive statewide continuing education program for employees and volunteers of facilities and organizations that provide prevention activities and treatment services. These education activities may be conducted by Department staff, through contracts with private nonprofit agencies, and collaboration with community coalitions and professional organizations.

Rhode Island's substance abuse training and education system has five primary components: an ICRC-recognized certification process, on-going workshops and training provided through a contract with a statewide training and advocacy association, conferences and institutes provided by the New England School of Addiction Studies, and training and technical assistance provided to State Incentive Grant sub-recipients and potential Strategic Prevention Framework State Incentive Grant sub-recipients through the Northeast Center for the Application of Prevention Technology (NECAPT), and cross-training with other Department units and the Department of Corrections. Other training and technical assistance is provided on an ad-hoc basis either by the Department or in collaboration with other federal, State or community agencies and organizations.

All Department contracts with organizations providing prevention, treatment or student assistance services continue to include a provision requiring the contracting entity to provide continuing education for their employees and to participate in any training mandated by the Department during the contract period.

PREVENTION AND TREATMENT

Rhode Island Board for the Certification of Chemical Dependency Professionals (RIBCCDP)

The Department provides funding through the SAPT Block Grant to the RI Board for the Certification of Chemical Dependency Professionals (RIBCCDP), which oversees the certification process for treatment, prevention, and Student Assistance Professionals, and Criminal Justice Professionals. The Board also provides technical

assistance to the Rhode Island College Chemical Dependency/Alcohol Studies Program. The Department is represented on the RIBCCDP Advisory Committee.

The RIBCCDP has begun to accommodate a significantly higher number of applicants for prevention certification as a result of the Department's Rules and Regulations for the Certification of Prevention Organizations, which mandates certification of individuals providing direct prevention/student assistance services through Department-funded organizations. The Department is collaborating with the RIBCCDP to ensure that appropriate training is available to those prevention providers who will be seeking certification as either prevention professionals or student assistance counselors.

The RIBCCDP has implemented the Certified Criminal Justice Addiction Professional credential for chemical dependency professionals specializing in the criminal justice area. The IRC approved Rhode Island's application for this specialty certification and the RIBCCDP is collaborating with DATA to develop training necessary to support this certification process. The Department is collaborating with the RIBCCDP to implement this certification process.

Drug and Alcohol Treatment Association of Rhode Island (DATA)

The Department contracts with DATA to oversee the statewide training and continuing education program for substance abuse and allied professionals. DATA continues to provide training to employees and volunteer staff of agencies and organizations engaged in substance abuse prevention, treatment and student assistance services as well as to staff of other State agencies and CBOs providing related services.

The Department also contracts with DATA of RI to operate "In-Rhodes" the State's resource center for substance abuse, HIV/AIDS, STD, suicide prevention and violence prevention, and issues related to co-occurring disorders. In-Rhodes is designated as the State's RADAR Network Center.

The annual DATA training curriculum is determined in consultation with prevention and treatment staff of the Department. Input is also provided by a Training Advisory Committee comprised of representatives from prevention, treatment, student assistance service organizations, a representative from the Addictions Technology Transfer Center at Brown University, and a member of the Corrections treatment community. A key element of DATA's training curriculum is a focus on incorporating evidence-based principles and best practices into the services provided by prevention and treatment organizations.

In conjunction with DATA's Training Coordinator, Department prevention staff is planning for expanded prevention training necessary to meet the education requirements for prevention professional certification.

DATA has a separate contract with the RI Department of Health to provide ongoing HIV/AIDS prevention and treatment training. The Department of Health is represented on the DATA Advisory Board and assists in the development and coordination of HIV/AIDS training for substance abuse professionals.

New England Institute of Addiction Studies

The Department is a member of the six-state New England Institute of Addiction Studies (NEIAS) and is represented on the Board of Directors Training Development Committee and an ad-hoc conference/workshop planning committee.

During FFY 2006, the Department co-sponsored and/or participated in the planning, coordination and implementation of the following institutes, conferences and workshops:

- The 40th annual New England School of Addiction Studies
- The 16th annual New England School of Best Practices in Addiction Treatment (formerly known as the Advanced School of Addiction Studies)
- The 6th annual New England School of Prevention Studies

Also, in order to promote the development and quality of our workforce, the Department, in collaboration with the Addiction Technology Transfer Center (ATTC-NE) and the New England Institute of Addiction Studies, coordinated and participated in the Fourth Annual Leadership Institute for Program Managers, and in the Career Exploration Project for students in RI colleges and in our State University.

During FFY 2006, the Department continues to offer scholarships to employees and volunteers of Department-funded agencies and organizations as well as to other State departments and agencies such as the Departments of Health; Children, Youth and Families; and Corrections to attend workshops and training sessions to promote awareness of substance abuse related issues, to improve the knowledge base and to increase collaboration to improve prevention and treatment services statewide.

Leadership Institute for Program Managers

In 2002 The Department began collaboration with the ATTC-NE to conduct a Workforce Survey of Direct Service Providers, which indicated real and perceived issues around workforce shortages. The Leadership Institute for Program Managers was developed to increase the retention and development of our next generation of leaders, and is now in its 4th full year in each New England State. The Department provides funding, the position of State Coordinator, and support to the applicants, their mentors, and the program.

Career Exploration Program

In order to more effectively address issues around staff recruitment, the Department assisted with funding, and participated in a Pilot Program in conjunction with NEIAS, the ATTC-NE, and a small number of academic institutions. Several students in other academic Human Service programs were chosen to participate in a special Career Exploration Track at the NESAS in Storrs, Ct, offered a time limited mentorship with a seasoned substance abuse professional, and given valuable resources such as tours of treatment agencies, introductions to networking opportunities, and easy access to the Coordinator at the Department.

Additional Prevention and Treatment Continuing Education during FFY 2006

During FFY 2006 a key area of concern of the Department is problems experienced by returning veterans and their families. Therefore, during FFY 2006 the Department implemented the following initiatives:

The Department continues collaboration with ATTC-NE and the Department of Veteran's Affairs to provide community wide education and assistance regarding substance abuse and mental health issues of returning veterans and their families.

The Department continues to collaborate with the RI National Guard Family Readiness Program to provide substance abuse and treatment related education to families of returning veterans

In FFY 2006, the Department developed it's own training curriculum for Behavioral Health Disaster Response Team. In September of 2006 Rhode Island received approximately 400 Hurricane Katrina evacuees that were temporarily relocated to Rhode Island. The Department provided support and assessment following their arrival. A Resource Center was established in collaboration with other service providers and State Departments. The Department provided Disaster Preparedness Education to responders from the substance abuse and mental health prevention and treatment community; hospitals, the American Red Cross-RI Chapter, and the police.

On an ongoing basis, prevention and treatment staff of the Department coordinate and/or provide technical assistance to substance abuse prevention and treatment providers funded by the SAPT Block Grant, Governor's Portion of Safe and Drug Free Schools and Communities, State Incentive Grant, and community prevention coalitions funded through the RI Substance Abuse Prevention Act. For example the Department coordinates training toward certification as required in the Rules and Regulations for the Certification of Prevention Organizations which applies to all MHRH-funded and contracted prevention service providers.

Department prevention and treatment staff participate in interagency, governmental, and community education and training, including planning, coordination, and

implementation of the statewide substance Abuse Treatment and Corrections Conference, and providing education and technical assistance across all treatment modalities regarding co-occurring disorders and the seamless integration of treatment.

The Department also participates in community education initiatives with other agencies, such as MADD and the RI State Police around effects and consequences of driving under the influence of substances.

In addition, Department staff provides technical assistance and education about substance abuse and related issues to allied agencies, departments and organizations that serve clients who may have issues related to substance abuse.

Department treatment staff planned coordinated and implemented the 3rd Annual Leadership Institute for Substance Abuse Treatment for Community Program Managers.

PREVENTION

State Incentive Grant (SIG)

During FFY 2006, the Department provided ongoing technical assistance and training to SIG sub-recipient community-based organizations. The SIG Program Manager coordinated technical assistance and training days provided by the Northeast CAPT as part of the State's work plan to achieve specified SIG training and technical assistance goals. Training and technical assistance related to the development and implementation of environmental strategies was provided in October 2005. Additional training and technical assistance related to program sustainability strategies was provided in May 2006.

GOAL #11

-- An agreement to provide continuing education for the employees of facilities which provide prevention activities and treatment services (See 42 U.S.C. 300x-28(b) and 45 C.F.R. 96.132(b)).

FFY 2007
INTENDED USE REPORT

In FFY 2007, the Department will continue to develop, implement and coordinate a comprehensive statewide continuing education program for employees and volunteers of facilities and organizations, which provide prevention activities and treatment services. These education activities may be conducted by Department staff, through contracts with private non-profit agencies, and collaboration with community coalitions and professional organizations.

Rhode Island's substance abuse training and education system has five primary components: an ICRC-recognized certification process, on-going workshops and training provided through a contract with a statewide training and advocacy association, conferences and institutes provided by the New England School of Addiction Studies, and training and technical assistance provided to State Incentive Grant sub-recipients through the Northeast Center for the Application of Prevention Technology (NECAPT), and cross-training with other Department units and the Department of Corrections. Additional training and technical assistance is provided on an ad-hoc basis either by the Department or in collaboration with other federal, State or community organizations.

All Department contracts with organizations providing prevention, treatment or student assistance services will continue to include a provision requiring the contracting entity to provide continuing education for their employees and to participate in any training mandated by the Department during the contract period.

PREVENTION AND TREATMENT

In FFY 2007, the Department will continue to develop, implement and coordinate a comprehensive statewide continuing education program for employees and volunteers of facilities and organizations that provide prevention activities and treatment services. These education activities may be conducted by Department staff, through contracts with private non-profit agencies, and collaboration with community coalitions and professional organizations.

Rhode Island's substance abuse training and education system has five primary components: an ICRC-recognized certification process, on-going workshops and training provided through a contract with a statewide training and advocacy association, conferences and institutes provided by the New England School of Addiction Studies, and training and technical assistance provided to State Incentive Grant sub-recipients

through the Northeast Center for the Application of Prevention Technology (NECAPT), and cross-training with other Department units and the Department of Corrections. Other training and technical assistance is provided on an ad-hoc basis either by the Department or in collaboration with other federal, State or community organizations.

All Department contracts with organizations providing prevention, treatment or student assistance services continue to include a provision requiring the contracting entity to provide continuing education for their employees and to participate in any training mandated by the Department during the contract period.

PREVENTION AND TREATMENT

Rhode Island Board for the Certification of Chemical Dependency Professionals (RIBCCDP)

The Department provides funding through the SAPT Block Grant to the RI Board for the Certification of Chemical Dependency Professionals (RIBCCDP), which oversees the certification process for treatment, prevention, and Student Assistance Professionals, and Criminal Justice Professionals. The Board also provides technical assistance to the Rhode Island College Chemical Dependency/Alcohol Studies Program. The Department is represented on the RIBCCDP Advisory Committee.

The RIBCCDP has begun to accommodate a significantly higher number of applicants for prevention certification as a result of the Department's Rules and Regulations for the Certification of Prevention Organizations, which mandates certification of individuals providing direct prevention/student assistance services through Department-funded organizations. The Department will collaborate with the RIBCCDP to ensure that appropriate training is available to those prevention providers who will be seeking certification as either prevention professionals or student assistance counselors.

The RIBCCDP has implemented the Certified Criminal Justice Addiction Professional credential for chemical dependency professionals specializing in the criminal justice area. The ICRC approved Rhode Island's application for this specialty certification and the RIBCCDP is collaborating with DATA to develop training necessary to support this certification process. The Department will collaborate with the RIBCCDP to implement this certification process.

Drug and Alcohol Treatment Association of Rhode Island (DATA)

The Department contracts with DATA to oversee the statewide training and continuing education program for substance abuse and allied professionals. DATA

continues to provide training to employees and volunteer staff of agencies and organizations engaged in substance abuse prevention, treatment and student assistance services as well as to staff of other State agencies and CBOs providing related services.

The Department also contracts with DATA of RI to operate "In-Rhodes" the State's resource center for substance abuse, HIV/AIDS, STD, suicide prevention and violence prevention, and issues related to co-occurring disorders. In-Rhodes is designated as the State's RADAR Network Center.

The annual DATA training curriculum is determined in consultation with prevention and treatment staff of the Department. Input is also provided by a Training Advisory Committee comprised of representatives from prevention, treatment, student assistance service organizations, a representative from the Addictions Technology Transfer Center at Brown University, and a member of the Corrections treatment community. A key element of DATA's training curriculum is a focus on incorporating evidence-based principles and best practices into the services provided by prevention and treatment organizations.

In conjunction with DATA's Training Coordinator, Department prevention staff is planning for expanded prevention training necessary to meet the education requirements for prevention professional certification.

DATA has a separate contract with the RI Department of Health to provide ongoing HIV/AIDS prevention and treatment training. The Department of Health is represented on the DATA Advisory Board and assists in the development and coordination of HIV/AIDS training for substance abuse professionals.

New England Institute of Addiction Studies

The Department is a member of the six-state New England Institute of Addiction Studies (NEIAS) and is represented on the Board of Directors Training Development Committee and an ad-hoc conference/workshop planning committee.

During FFY 2007, the Department will co-sponsor and/or participate in the planning, coordination and implementation of the following institutes, conferences and workshops:

- The 41st annual New England School of Addiction Studies
- The 17th annual New England School of Best Practices in Addiction Treatment (formerly known as the Advanced School of Addiction Studies)
- The 7th annual New England School of Prevention Studies

Also, in order to promote the development and quality of our workforce, the Department, in collaboration with the Addiction Technology Transfer Center (ATTC-NE) and the New England Institute of Addiction Studies, will coordinate and

participate in the Fifth Annual Leadership Institute for Program Managers, and in the Career Exploration Project for students in RI colleges and in our State University.

During FFY 2007, the Department will continue to offer scholarships to employees and volunteers of Department-funded agencies and organizations as well as to other State departments and agencies such as the Departments of Health; Children, Youth and Families; and Corrections to attend workshops and training sessions to promote awareness of substance abuse related issues, to improve the knowledge base and to increase collaboration to improve prevention and treatment services statewide.

Leadership Institute for Program Managers

In 2002 The Department began collaboration with the ATTC-NE to conduct a Workforce Survey of Direct Service Providers, which indicated real and perceived issues around workforce shortages. The Leadership Institute for Program Managers was developed to increase the retention and development of our next generation of leaders, and in FFY 2007 will be in its 5th year in each New England State. The Department will continue funding, the position of State Coordinator, and support to the applicants, their Mentor, and the Program.

Career Exploration Program

In order to more effectively address the issues around staff recruitment, the Department assisted with funding, and participated in a Pilot Program in conjunction with NEIAS, the ATTC-NE, and a small number of academic institutions. Several students in other academic Human Service programs were chosen to participate in a special Career Exploration Track at the NESAS in Storrs, Ct, offered a time limited mentorship with a seasoned substance abuse professional, and given valuable resources such as tours of treatment agencies, introductions to networking opportunities, and easy access to the Coordinator at the Department.

Additional Prevention and Treatment Continuing Education during FFY 2007

The Department will continue to provide Disaster Preparedness Education to responders from the substance abuse and mental health prevention and treatment community; hospitals, the American Red Cross-RI Chapter, and the police.

In FFY 2007 on an ongoing basis, prevention and treatment staff of the Department will continue to coordinate and/or provide technical assistance to substance abuse prevention and treatment providers funded by the SAPT Block Grant, Governor's Portion of Safe and Drug Free Schools and Communities, State Incentive Grant, and community prevention coalitions funded through the RI Substance Abuse Prevention Act. For example the Department coordinates training toward certification as required

in the proposed Rules and Regulations for the Certification of Prevention Organizations which applies to all MHRH-funded and contracted prevention service providers.

Department prevention and treatment staff will continue to participate in interagency, governmental, and community education and training; and will provide education and technical assistance across all treatment modalities regarding co-occurring disorders and the seamless integration of treatment.

The Department will also participate in community education initiatives with other agencies, such as MADD and the RI State Police around effects and consequences of driving under the influence of substances.

Department treatment staff will plan, coordinate and implement the 4th Annual Leadership Institute for Substance Abuse Treatment for Community Program Managers.

PREVENTION

State Incentive Grant (SIG)

During FFY 2007, the Department will provide ongoing technical assistance and training to SIG sub-recipient organizations. The SIG Program Manager will coordinate technical assistance and training days provided by the Northeast CAPT as part of the State's work plan to achieve specified SIG training and technical assistance goals.

Rhode Island

Goal #12: Coordinate Services

GOAL # 12. An agreement to coordinate prevention activities and treatment services with the provision of other appropriate services (See 42 U.S.C. 300x-28(c) and 45 C.F.R. 96.132(c)).

FY 2004 (Compliance):

FY 2006 (Progress):

FY 2007 (Intended Use):

GOAL # 12

-- An agreement to coordinate prevention activities and treatment services with the provision of other appropriate services (See 42 U.S.C. 300x-28(c) and 45 C.F.R. 96.132(c)).

FFY 2004
COMPLIANCE REPORT

In FFY2004, the state:

Completed the Statewide Substance Abuse Prevention Plan as part of the State Incentive Grant. Key components of the plan stress coordination and collaboration in the delivery of substance abuse prevention services among state agencies in partnership with communities of interest. The Governor has tasked his Children's Cabinet with providing innovative recommendations for funding redirection and prevention system design. The Children's Cabinet consists of all State Department Directors and is responsible, by statute, for addressing all cross-departmental issues that relate to children's needs and services. The Children's Cabinet was advised by a SIG Advisory Committee, the Statewide Prevention Planning Committee made up of representatives of all State agencies represented on the Children's Cabinet, prevention providers, community coalitions, minority groups, health care organizations and private sector representatives. Local input was provided through direct representation of diverse constituencies.

Conducted, as part of the SIG, an analysis of current prevention funding streams across all state agencies/departments providing prevention services to children and youth

Participated on and collaborated with the Interagency Coordinating Team to decrease duplicative efforts by sharing information and conducting joint planning sessions

Continued extensive collaboration with the Department of Health on a number of issues, particularly Synar, HIV/TB initiatives, and common legislative issues

Continued to provide training for mental health and substance abuse treatment staff working with dually diagnosed persons

Continued to collaborate with the Department of Children, Youth and Families, the Departments of Education and Corrections and the Criminal Justice System related to any substance abuse issues, to increase the emphasis on substance abuse and the criminal justice system (e.g. treatment for incarcerated populations, Treatment Alternatives for Safer Communities (TASC) initiatives) and the potential creation of drug courts

Continued to be represented on the State Child Opportunity Zones (COZ) policy and

coordinating committees

Offered scholarships to staff of other state departments and agencies through our training contract to attend substance abuse prevention and treatment specific workshops to establish linkages to effectively deal with clients and the community

Continued to participate on the State COZ policy and coordinating committees in conjunction with the Department of Education

Continued funding In-Rhodes, the resource library of literature, films, etc. related to substance abuse for use by educators, law enforcement, community providers and citizen groups, as well as the public at large

Continued to collaborate with local police departments and community coalitions on the implementation of the Synar Requirements

Continued to work with Emergency Management, Public Health, Human Service and other organizations on Behavioral Health Disaster Preparedness issues

Continued to work with Superior and Family Court to provide Adult and Family Drug Court Services

Implemented the interagency work plan with the Department of Health regarding viral hepatitis, which includes cross training of all behavioral healthcare providers as well as health centers providing HIV/AIDS services

Continued through the Governor's Council on Behavioral Health to advise the governor and general assembly on policies, goals, and operations of the behavioral healthcare program, including the program areas of substance abuse and mental health, and on other matters the director of Mental Health, Retardation and Hospitals refers to it and to encourage public understanding and support of the behavioral health program

Conducted a request for proposals for the General Outpatient Patient System

GOAL # 12

-- An agreement to coordinate prevention activities and treatment services with the provision of other appropriate services (See 42 U.S.C. 300x-28(c) and 45 C.F.R. 96.132(c)).

FFY 2006
PROGRESS REPORT

In FFY 2006 the Department works collaboratively with a variety of governmental and community-based organizations to coordinate substance abuse prevention and treatment services with the provision of other related services. Initiatives conducted during FFY 2006 are consistent with the Department's strategic plan, which promotes the provision of comprehensive client-focused services

PREVENTION

In FFY 2006 the Department, through the SIG Project Manager, continued to assist the Governor's Children's Cabinet in coordinating a plan of action for the implementation of the SIG Statewide Substance Abuse Prevention Plan. The Youth Development Advisory Committee of the Cabinet (YDAC) continues to be the catalyst for implementing the recommendations made in the Plan. The YDAC has created workgroups to address the development of an implementation plan, which includes the assistance of the State Epidemiological Outcomes Workgroup (SEOW) under the Strategic Prevention Framework State Incentive Grant (SPF SIG) initiative. The SPF SIG team will guide the strategic planning of 11 out of the 15 recommendations contained in the State Prevention Plan and will report back regularly to the YDAC. The YDAC monitors the progress of the SEOW on a quarterly basis and facilitates interagency collaboration in implementing the Plan. The SIG Project manager continued to assist the Children's Cabinet by facilitating administrative and technical assistance to the Youth Development Advisory Committee.

The Department continues to participate on and collaborate with the SIG Interagency Coordinating Team to decrease duplicative efforts by sharing information and conducting joint planning sessions. Interagency Coordinating Team members are represented on the YDAC workgroups, which continue to develop strategic plans for implementing the recommendations made in the State Plan. In addition, members of the Interagency Coordinating Team continue to participate in planning sessions regarding initiatives, which affect populations targeted by multiple state agencies.

During FFY 2006 management coordination between the State Incentive Grant and Strategic Prevention Framework State Incentive Grant has and will continue to include regular meetings between the SIG Project Manager, SPF SIG Team members, and the Department's Chief of Prevention and Planning regarding leveraging and coordinating SIG 1 and SPF SIG resources to enhance state infrastructure development. Two major

foci are joint planning and development of the RI State Work Plan in conjunction with the Northeast CAPT and development of strategies for incorporating outcomes and learning from the two SIG into the Department's prevention and treatment planning activities.

A prevention staff member within the Department serves as the Program Manager for the USDOE, Governor's Portion of the Safe and Drug Free Schools and Communities Grant. Departmental prevention staff works collaboratively with staff from the RI Department of Education on the State's coordinated SDFSC State plan.

During FFY 2006 Department staff continue to work collaboratively with other State and local agencies and organizations to ensure compliance with the survey and enforcement provisions of the federal Synar Amendment. Partners included the RI Department of Health, State and local police departments and local substance abuse prevention task forces.

A prevention staff member within the Department serves as the State's Enforcing Underage Drinking Laws (EUDL) Coordinator. The EUDL Coordinator convenes and staffs the EUDL Advisory Committee, which is comprised of representatives from State agencies, legislators, business, local and state law enforcement, and community-based organizations and coalitions.

The Department, through the EUDL Coordinator, collaborated with the RI Division of Business Regulation, MADDRI and the University of RI to amend the State's Responsible Beverage Server Training Law passed by the General Assembly in 2004. Policy makers were educated regarding the need to require that programs teaching responsible beverage service be based on "best practices." The proposed amendment subsequently passed the General Assembly and was signed into law by the Governor.

During FFY 2006, the Department promulgated rules and regulations for the certification of training programs that teach responsible beverage service. The Department also reviewed and approved for certification server training programs meeting the requirements of the law. In addition, the Department initiated development of monitoring protocols for certified training programs.

During FFY 2006, the Department continues to coordinate monthly meetings of the statewide network of substance abuse prevention task forces. These meetings provide a vehicle for other state and community agencies/organizations to solicit task force support for initiatives related to substance abuse prevention. Examples of on-going collaboration in FFY 2006 include efforts by a majority of the task forces to educate their respective communities about problem gambling; and joint planning by the Department, the State Office on Highway Safety, MADDRI and the task forces to host alcohol-free family dinners during the 2005 holiday season.

During FFY 2006, prevention staff from the Department continues to work collaboratively with staff from the RI Department of Health to implement and enforce the

provisions of the State's smoke-free statute and coordinate the efforts of the statewide network of community substance abuse prevention task forces to assist in this process.

The RI Department of Health is funded by the CDC to lead a statewide initiative to prevent youth violence (STOP It). As part of this initiative a staff member from the Department's Prevention Unit serves on the Child and Adolescent Violence Prevention Advisory Committee (CAVPAC) as well as on the risk and protective factor workgroup and the policy workgroup.

TREATMENT

In FFY 2006, the Department's Treatment Unit is continuing collaborative efforts with sister State agencies to promote better systems of care for clients with substance abuse related issues. Specifically, the Department:

Is implementing the interagency work plan with the Department of Health regarding viral hepatitis, which includes cross training of all behavioral healthcare providers as well as community health centers providing HIV/AIDS services;

Is participating in cross training initiatives, and provision of technical assistance with shelters that provide assistance to homeless women and those who are affected by domestic violence;

Is participating in cross training initiatives, and provision of technical assistance with the Division of Developmental Disabilities;

Continues to work on developing and implementing services targeting pregnant women, women with dependant children, and children and youth in conjunction with the State agencies who serve these target populations. Specifically, the Department continues collaboration with the RI Department of Children Youth and Families (DCYF) regarding reunification issues and access to and payment for treatment services for women and children with substance abuse issues, and with the Department of Health regarding Women's Health and Special Issues;

Continues collaboration with the Departments of Corrections, Labor and Training, Human Services, DCYF, Housing, and other relevant agencies in order to reduce recidivism among persons with substance abuse and mental health issues involved with the criminal justice system. The Department also continues to work with Emergency Management, public health, human service and other organizations on behavioral health disaster preparedness issues;

In FFY 2006, the Department's Drug Court Liaison continued working with Superior and Family Courts to provide Adult and Family Drug Court Services and education and technical assistance to the Domestic Violence Court, Juvenile Drug Court, and their Advisory Boards.

PREVENTION AND TREATMENT

During FFY 2006, the Department also continues to plan and implement a number of initiatives intended to improve coordination, which include both prevention and treatment components. Specifically the Department:

Collaborates with the Department of Health on a number of issues, particularly maternal and child health issues, implementation of mechanisms to fulfill the Synar Amendment requirements, HIV/TB initiatives, common legislative issues, and increased participation in interdepartmental RFP's especially as they relate to issues of substance abuse/health promotion;

Convenes a planning team to guide the implementation of the *Rhode Island State Action Plan for an Integrated Co-Occurring Disorders System of Care*, which was developed following attendance at a Co-Occurring Policy Academy. The plan addresses prevention, early intervention, treatment, and recovery strategies. The planning team includes the Directors (or representative) from the Departments of Corrections; Elderly Affairs; Human Services; Children, Youth and Families; and Mental Health, Retardation and Hospitals, in addition to representatives of consumer and advocacy groups, community-based treatment and prevention service providers, and other stakeholders. The Co-Occurring Center for Excellence (COCE) will provide onsite technical assistance for a mini policy academy to orient the new members of the planning team.

Provides scholarships to staff of other state departments and agencies through our training contract to attend substance abuse prevention and treatment specific workshops to establish linkages to effectively deal with clients and the community;

Continues funding for In-Rhodes, the statewide resource center, for issues related to substance abuse for use by educators, law enforcement, community providers and citizen groups, as well as the public at large;

Maintains on-going efforts with Emergency Management, public health, human service and other organizations on behavioral health disaster preparedness issues;

Continues to staff and provide technical assistance to the Governor's Council on Behavioral Health. The Council continues to advise the Governor and General Assembly on policies, goals, and operations of the behavioral healthcare system, including the program areas of substance abuse and mental health, and on other matters the Director of Mental Health, Retardation and Hospitals refers to it. The Council also encourages public understanding and support of the behavioral health program;

Continues to sponsor events and opportunities that include non-traditional and collateral providers, including faith-based, multicultural agencies and community

health centers, in order to increase networking opportunities and strengthen connections among all providers;

Continues funding scholarships to staff of other state departments and agencies to attend substance abuse prevention and treatment specific workshops, and the New England Schools of Prevention and Addiction Studies

GOAL # 12

-- An agreement to coordinate prevention activities and treatment services with the provision of other appropriate services (See 42 U.S.C. 300x-28(c) and 45 C.F.R. 96.132(c)).

FFY 2007
INTENDED USE REPORT

In FFY 2007 the Department will continue to work collaboratively with a variety of governmental and community-based organizations to coordinate substance abuse prevention and treatment services with the provision of other related services. Initiatives conducted during FFY 2007 will be consistent with the Department's strategic plan, which promotes the provision of comprehensive client-focused services

PREVENTION

During FFY 2007 management coordination between the State Incentive Grant and Strategic Prevention Framework State Incentive Grant will continue to include regular meetings between the SIG Project Manager, SPF SIG Team members, and the Department's Chief of Prevention and Planning regarding leveraging and coordinating SIG 1 and SPF SIG resources to enhance state infrastructure development. Two major foci are joint planning and development of the RI State Work Plan in conjunction with the Northeast CAPT and development of strategies for incorporating outcomes and learning from the two SIG into the Department's prevention and treatment planning activities.

A prevention staff member within the Department serves as the Program Manager for the USDOE, Governor's Portion of the Safe and Drug Free Schools and Communities Grant. During FFY 2007, Department prevention staff will continue to work collaboratively with staff from the RI Department of Education to implement the State's coordinated SDFSC annual State plan. The Department will also initiate and complete development of the re-competition of the Governor's Portion of SDFSC funds in order to incorporate the steps of the SPF into this funding stream.

Department prevention staff will continue to be represented on the State's School Health Advisory Council (SHAC), which is comprised of representatives from governmental, and community based organizations serving school-aged children. The SHAC promotes the development and implementation of comprehensive, evidence-based school health programs.

During FFY 2007 Department staff will continue to work collaboratively with other State and local agencies and organizations to ensure compliance with the survey and enforcement provisions of the federal Synar Amendment. Partners will include the RI

Department of Health, State and local police departments and local substance abuse prevention task forces.

A prevention staff member within the Department serves as the State's Enforcing Underage Drinking Laws (EUDL) Coordinator. During FFY 2007 Department, the EUDL Coordinator will continue to convene and staff the EUDL Advisory Committee, which is comprised of representatives from State agencies, legislators, business and community-based organizations.

During FFY 2007, the Department will implement protocols for monitoring certified training programs and continue to review curricula submitted for certification.

During FFY 2007, the Department will continue to coordinate monthly meetings of the statewide network of substance abuse prevention task forces. These meetings provide a vehicle for other state and community agencies/organizations to solicit task force support for initiatives related to substance abuse prevention. Examples of on-going collaboration which will continue in FFY 2007 include efforts by a majority of the task forces to educate their respective communities about problem gambling; and joint planning by the Department, the State Office on Highway Safety, MADDRI and the task forces to host alcohol-free family dinners during the upcoming 2007 holiday season.

During FFY 2007, prevention staff from the Department will continue to work collaboratively with staff from the RI Department of Health to implement and enforce the provisions of the State's smoke-free statute and coordinate the efforts of the statewide network of community substance abuse prevention task forces to assist in this process.

The RI Department of Health is funded by the CDC to lead a statewide initiative to prevent youth violence (STOP It). As part of this initiative a staff member from the Department's Prevention Unit will continue to serve on the Child and Adolescent Violence Prevention Advisory Committee (CAVPAC) as well as on the risk and protective factor workgroup and the policy workgroup.

TREATMENT

During FFY 2007, the Department will:

Continue monitoring of the new standards, regulatory and monitoring tools for the General Outpatient Patient System that was begun in July 2005;

Continue monitoring and provision of technical assistance to treatment agencies participating in the redesigned outpatient treatment contracts. These contracts require regional partnerships with other behavioral health providers to provide a seamless continuum of care throughout the state. The partnerships are intended to ensure that ancillary services are provided in a timely manner, with service accessibility, case management and aftercare seen as major components;

Continue monitoring and provision of technical assistance to residential and methadone treatment agencies with State contracts, including identification and resolution of issues related to compliance with new behavioral health care standards and contract specifications;

Continue receipt and investigation of consumer complaints and agency generated Incident Reports;

Continue provision of education and training for mental health and substance abuse treatment staff working with dually-diagnosed persons; and

Continue provision of education, training, and technical assistance to substance abuse and mental health agencies to improve coordination of referrals and treatment among ancillary systems and each other

In FFY 2007, the Department's Treatment Unit will continue collaborative efforts with sister State agencies to promote better systems of care for clients with substance abuse related issues. Specifically, the Department will:

Continue to implement the interagency work plan with the Department of Health regarding viral hepatitis, which includes cross training of all behavioral healthcare providers as well as community health centers providing HIV/AIDS services,

Continue to participate in cross training initiatives, and provision of technical assistance with shelters that provide assistance to homeless women and those who are affected by domestic violence.

Continue to promote and participate in cross training initiatives, and provision of technical assistance within the Department of Behavioral Healthcare Services, with the addition of the Department of Developmental Disabilities.

Continue to develop and implement services targeting pregnant women, women with dependant children, and children and youth in conjunction with the State agencies who serve these target populations. Specifically, the Department continues collaboration with the RI Department of Children Youth and Families (DCYF) regarding reunification issues and access to and payment for treatment services for women and children with substance abuse issues, and with the Department of Health regarding Women's Health and Special Issues;

Implement monitoring, and provision of technical assistance, through licensing regulations, to improve coordination of activities related to treatment services provided to incarcerated individuals at the Adult Corrections Institution.

Continue collaboration with the Departments of Corrections, Employment and Training, Human Services, DCYF, Housing, and other relevant agencies in order to reduce recidivism among persons with substance abuse and mental health issues involved with the criminal justice system.

Continue to support, monitor, and fund training and treatment for persons with compulsive gambling disorders, and to provide technical assistance with coordination of other related treatment issues.

Continue to provide education and technical assistance to the Domestic Violence Court, Juvenile Drug Court, and their Advisory Boards.

The Drug Court Liaison will continue to work with the Superior and Family Courts to provide Adult and Family Drug Court Services.

PREVENTION AND TREATMENT

During FFY 2007, the Department will continue to plan and implement a number of initiatives intended to improve coordination, which include both prevention and treatment components. The Department also will continue to plan and implement a number treatment components. Specifically the Department will:

Collaborate with the Department of Health on a number of issues, particularly maternal and child health issues, implementation of mechanisms to fulfill the Synar Amendment requirements, HIV/TB initiatives, common legislative issues, and increased participation in interdepartmental RFP's especially as they relate to issues of substance abuse/health promotion;

Support the planning team guiding the implementation of the *Rhode Island State Action Plan for an Integrated Co-Occurring Disorders System of Care*, which was developed following attendance at a Co-Occurring Policy Academy. The plan addresses prevention, early intervention, treatment, and recovery strategies. The planning team includes the Directors (or representative) from the Departments of Corrections; Elderly Affairs; Human Services; Children, Youth and Families; and Mental Health, Retardation and Hospitals, in addition to representatives of consumer and advocacy groups, community-based treatment and prevention service providers, and other stakeholders;

Continue to fund scholarships to staff of other state departments and agencies for substance abuse prevention and treatment specific workshops, and the New England Schools of Prevention and Addiction Studies;

Continue to funding for In-Rhodes, the statewide resource center, for issues related to substance abuse for use by educators, law enforcement, community providers and citizen groups, as well as the public at large;

Continue to work with Emergency Management, public health, human service and other organizations on behavioral health disaster preparedness issues.

Continue providing staff support and technical assistance to the Governor's Council on Behavioral Health. The Council will continue to advise the Governor and General Assembly on policies, goals, and operations of the behavioral healthcare system, including the program areas of substance abuse and mental health and on other matters the Director of Mental Health, Retardation and Hospitals refers to it. The Council also encourages public understanding and support of the behavioral health program;

Continue to sponsor events and opportunities that include non-traditional and collateral providers, including faith-based, multicultural agencies and community health centers, in order to increase networking opportunities and strengthen connections among all providers;

Through its training contract continued to fund scholarships to staff of other state departments and agencies to attend substance abuse prevention and treatment specific workshops, and the New England Schools of Prevention and Addiction Studies

Rhode Island

Goal #13: Assessment of Need

GOAL # 13. An agreement to submit an assessment of the need for both treatment and prevention in the State for authorized activities, both by locality and by the State in general (See 42 U.S.C. 300x-29 and 45 C.F.R. 96.133).

FY 2004 (Compliance):

FY 2006 (Progress):

FY 2007 (Intended Use):

Goal # 13.

- *An agreement, to submit an assessment of the need for both treatment and prevention in the State for authorized activities, both by locality and by the State in general.*

FFY 2004
COMPLIANCE REPORT

In FFY 2004, the state:

Continued to require all prevention providers (including SAPT 20% set-aside, task forces, Safe & Drug Free Schools and Communities and SIG s-funded programs) to enter data on a monthly basis (at a minimum) into the PBPS web based MIS, thereby increasing the available pool of data required for a state level needs assessment;

Continued to utilize information obtained through the conduct of the SALT, YRBS, YTS surveys, and Kids Count to determine substance abuse prevention needs of youth;

Continued to work with other state agencies to insure that behavioral health questions are included in adult surveys (e.g., BRFSS);

Continued to use the FFY 2002 assessment of treatment needs, *Study of Rhode Island's Substance Abuse Treatment Service Needs,* and data contained in the Client Information System as the bases for planning, program development, and funding; and continued to utilize national data sources, (e.g., the National Survey on Drug Use and Health) and state and local data to guide prevention and treatment planning;

Continued to require that municipal task forces/coalitions conduct local a local needs assessment every year; and

Continued analyzing the needs of the treatment system utilizing MIS data, utilization data, and other planning and technical assistance reports.

Goal # 13.

- *An agreement, to submit an assessment of the need for both treatment and prevention in the State for authorized activities, both by locality and by the State in general.*

FFY 2006
PROGRESS REPORT

During FFY 2006, the Department continues efforts to develop a statewide surveillance system that ultimately will enable the State to submit an overall assessment of prevention and treatment need for authorized activities, both at the state and local level. In FFY 2006, the Department is implementing the following initiatives:

PREVENTION

The Department continues to utilize information obtained through the conduct of several school based surveys, the School Accountability for Learning and Teaching (SALT) Survey administered to elementary, middle school and high school students; the Youth Risk Behavior Survey (YRBS) administered to a sample of high school students, and the Youth Tobacco Survey (YTS) administered to a sample of middle and high school students. Through collaboration with other State agencies involved with the administration of these surveys, the Department has included several key AOD-related items in the survey instruments (e.g., questions were included regarding age of first use of AOD, past 30 day use of AOD, perception of risk associated with use of AOD, peer approval of AOD use, parental expectations, and binge drinking). In FFY 2005, the Department modified one YTS question to determine the sources from which youth are most likely to obtain alcohol products. Efforts in FFY 2006 will focus on increasing school participation rates for the YRBS and the YTS.

Information collected through the conduct of these surveys as well as from information contained in annual RI Kids Count reports continues to be utilized by the Department and other State agencies as well as by CBO's and substance abuse prevention task forces to determine the substance abuse prevention needs of youth in the State. State agencies, in particular, continue to utilize this information to develop Requests for Proposals and to apply for federal and/or foundation funding. The Department continues to require CBO's and local substance abuse prevention task forces to utilize relevant information from these sources to develop grant applications and annual prevention program service plans.

The Department continues to have representation on the ad-hoc Student Health Survey Committee which advocates for on-going data collection and analysis as well as for the timely dissemination of statistics related to the health and well-being of School-aged children and youth in the State.

The Department continues to support the work of the State Epidemiological Outcome Workgroup (SEOW) created under the SPF SIG to oversee the development of the State's surveillance system of consumption patterns and consequences related to substance use. During FFY 2006, the SEOW is inventorying current surveillance assets, including survey and social indicator data sets relevant to substance abuse risk and protective factors.

The SEOW is developing state-level and municipal-level "community profiles" based on available substance abuse risk and protective factor data, which subsequently will be utilized to determine which communities are eligible for SPF SIG funding based on documented need for specific services. These state-level and community-level profiles will be utilized by the Department to support statewide prevention planning and will be made available to the local task forces for development of municipal-level prevention service plans, community education and the preparation of grant applications. Other Department-funded prevention and treatment agencies will have access to the profiles to support their service plans and grant application development.

All substance abuse prevention task forces have completed comprehensive community needs assessments and have incorporated the findings into their FFY 2006 community program service plans.

The Department continues to include a provision in contracts between the Department and all non student assistance providers (including providers receiving funding under the SAPT Block grant, the SIG, the RI Substance Abuse Prevention Act and the Governor's Portion of the Safe and Drug Free Schools and Communities Grant) requiring that prevention service delivery data be entered at least monthly on PBPS, the Department's MIS. The Department prevention staff continues to conduct training sessions for service providers on PBPS data entry as needed.

The Department continues to work collaboratively with the PBPS provider, KIT Solutions, to refine the system to collect community prevention data. During FFY 2006, Department Prevention Unit staff will focus on incorporating a new coalition model, currently in development by KIT Solutions into Rhode Island's PBPS. A second priority will be to ensure that State Outcome Measures (SOMS) related indicators are being collected (as appropriate) by prevention providers and that the PBPS modules will permit the Department to report SOM outcomes as required.

The Department is working with the providers of student assistance program services on development of a computer-based management information system, moving the providers from a paper-based reporting system to an electronic one.

TREATMENT

The Department will continue to utilize results from Phases I and II of the CSAT-funded State Demand and Needs Assessment Studies in preparing grant applications and in

assisting other State Departments/agencies (e.g., the Departments of Health; Corrections; and Children, Youth and Families; and the judicial system) by providing needs assessment data for use in the development of various grant applications. Needs assessment results will be utilized to support Department budget preparation and for legislative hearings; as well as for general planning purposes.

The Department will continue to analyze the needs of the treatment system using needs assessment data, as well as information from MIS data, utilization data, and other planning and technical assistance reports. The Department will continue to identify trends in the utilization of treatment services in relation to gender, age, education, employment, primary drug of choice, prior treatment history, criminal justice involvement and housing. Needs assessment results will be used to determine future state and federal resource allocation activity.

The Department has continued to use information on system needs gathered through focus groups conducted with providers and community groups in SFY 2005.

PREVENTION AND TREATMENT

The Department will provide statewide training to agencies on National Outcome Measures (NOMS) and SOMS in order to implement data-driven performance management, and to improve service outcomes.

The Governor's Council on Behavioral Health has requested that the Division of Behavioral Healthcare Services initiate development of a behavioral health strategic plan to guide planning and program development. The first phase of development is a review of previously published plans and preparation of a status report, which was completed in FFY 2006.

The Department will continue to use information from the Prevention and Treatment management information systems (the PBPS and CIS, respectively) for planning and policy decisions.

Goal # 13.

- *An agreement, to submit an assessment of the need for both treatment and prevention in the State for authorized activities, both by locality and by the State in general.*

FFY 2007
INTENDED USE REPORT

In FFY 2007, the Department will continue efforts to develop a statewide surveillance system that ultimately will enable the State to submit an overall assessment of prevention and treatment need for authorized activities, both at the state and local level. In FFY 2007, the Department intends to implement the following initiatives:

PREVENTION

The Department will continue to utilize information obtained through the conduct of several school based surveys, including the School Accountability for Learning and Teaching (SALT) Survey administered to elementary, middle school and high school students; the Youth Risk Behavior Survey (YRBS) administered to a sample of high school students, and the Youth Tobacco Survey (YTS) administered to a sample of middle and high school students. Through collaboration with other State agencies involved with the administration of these surveys, the Department was able to include several key AOD-related items in the survey instruments (e.g., questions were included regarding age of first use of AOD, past 30 day use of AOD, perception of risk associated with use of AOD, peer approval of AOD use, parental expectations, and binge drinking). In FFY 2005, the Department modified one YTS question to determine the sources from which youth are most likely to obtain alcohol products. Efforts in FFY 2007 will focus on the YRBS.

Information collected through the conduct of these surveys as well as from information contained in annual RI Kids Count reports will continue to be utilized by the Department and other State agencies as well as by CBO's and substance abuse prevention task forces to determine the substance abuse prevention needs of youth in the State. State agencies, in particular, will continue to utilize this information to develop Requests for Proposals and to apply for federal and/or foundation funding. The Department will continue to require CBO's and local substance abuse prevention task forces to utilize relevant information from these sources to develop grant applications and annual prevention program service plans.

The Department will continue to have representation on the ad-hoc Student Health Survey Committee which will continue to advocate for on-going data collection and analysis as well as for the timely dissemination of statistics related to the health and well-being of School-aged children and youth in the State.

The Department will continue to support the work of the State Epidemiological Workgroup (SEOW) created under the SPF SIG. The SEOW will develop state-level and municipal-level "community profiles" based on available substance abuse risk and protective factor data, which subsequently will be utilized to determine which communities are eligible for SPF SIG funding based on documented need for specific services. These state-level and community-level profiles ultimately will be utilized by the Department to support statewide prevention planning and will be made available to the local task forces for development of municipal-level prevention service plans, community education and the preparation of grant applications. Other Department-funded prevention and treatment agencies will have access to the profiles to support their service plans and grant application development.

Substance abuse prevention task forces will continue to incorporate the findings their comprehensive community needs assessments into their FFY 2007 annual program plans.

The Department will continue to include a provision in contracts between the Department and all non student assistance providers (including providers receiving funding under the SAPT Block grant, the SIG, and the Governor's Portion of the Safe and Drug Free Schools and Communities Grant) requiring that prevention service delivery data be entered at least monthly on PBPS, the Department's MIS. The Department prevention staff will continue to conduct training sessions for service providers on PBPS data entry as needed during FFY 2007.

The Department will continue to work collaboratively with the PBPS provider, KIT Solutions, to refine the system to collect community prevention data. During FFY 2007, Department staff will focus on incorporating a new coalition model, currently in development by KIT Solutions, into Rhode Island's PBPS. A second priority will be to ensure that State Outcome Measures (SOMS) related indicators are being collected (as appropriate) by prevention providers and that the PBPS modules will permit the Department to report SOM outcomes as required. The PBPS provider, KIT Solutions, will continue to produce annual state and local-level reports of services provided, broken down by funding source, program, service category, and target population. The new coalition module will be implemented and its utility monitored.

TREATMENT

The Department will continue to utilize results from Phases I and II of the CSAT-funded State Demand and Needs Assessment Studies in preparing grant applications and in assisting other State Departments/agencies (e.g., the Departments of Health; Corrections; and Children, Youth and Families; and the judicial system) by providing needs assessment data for use in the development of various grant applications. Needs assessment results will be utilized to support Department budget preparation and for legislative hearings; as well as for general planning purposes.

The Department will initiate use of a merged MIS, incorporating the formerly separate mental health and substance abuse treatment client information systems. Staff will facilitate the final development of the system and monitor its use as it is rolled out to the provider communities.

The Department will continue to analyze the needs of the treatment system using needs assessment data, as well as information from MIS data, utilization data, and other planning and technical assistance reports. The Department will continue to identify trends in the utilization of treatment services in relation to gender, age, education, employment, primary drug of choice, prior treatment history, criminal justice involvement and housing. Needs assessment results will be used to determine future state and federal resource allocation activity. The Department will also explore the feasibility of changing the process used to collect information about the number of treatment-seekers who are unable to be accommodated in a timely fashion.

PREVENTION AND TREATMENT

The Department will provide statewide training to agencies on National Outcome Measures (NOMS) and SOMS in order to implement data-driven performance management, and to improve service outcomes.

The Department will continue development of a behavioral health strategic plan. Plans for FFY 2007 include developing indicators of need for behavioral healthcare (mental health and substance abuse) services. Reports resulting from this process will be posted at the Governor's Council section of the Department's website: http://www.mhrh.ri.gov/bh_gov_council.htm.

The Department will continue to collaborate with the SEOW supported through the SPF SIG. Collaboration with the SEOW will include contributions to identifying behavioral healthcare services indicators (see above).

The Department will continue implementation of the *RI State Action Plan for an Integrated COD System of Care*, including initial work on Strategy 2.1: "Enhance the data infrastructure to capture information related to COD rates and services."

Rhode Island

Goal #14: Hypodermic Needle Program

GOAL # 14. An agreement to ensure that no program funded through the block grant will use funds to provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs (See 42 U.S.C. 300x-31(a)(1)(F) and 45 C.F.R. 96.135(a)(6)).

FY 2004 (Compliance):

FY 2006 (Progress):

FY 2007 (Intended Use):

GOAL # 14

-- An agreement to ensure that no program funded through the block grant will use funds to provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs (See 42 U.S.C. 300x-31(a)(1)(F) and 45 C.F.R. 96.135(a)(6)).

FFY 2004 (Compliance):

FFY 2006 (Progress):

FFY 2007 (Intended Use):

GOAL # 14. An agreement to ensure that no program funded through the block grant will use funds to provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs.

In FFY2004, the state:

- Continued to include language in the contracts that prohibits this activity with federal dollars.

In FFY2006, the state:

- Continues to include language in the contracts that prohibits this activity with federal dollars.

In FFY2007, the state will:

- Continue to include language in the contracts that prohibits this activity with federal dollars.

A. General Requirements - All Treatment Services Contract Language

1. The provider agrees to utilize any standardized assessment instrument, as well as outcome measurement instruments, which may be adopted by the Department during the contract period.
2. The Provider shall provide continuing education for its employees.
3. The Provider agrees to carry on outreach activities for the purpose of encouraging people in need of treatment to seek assistance.
4. Prohibited Use of Funds:
   a. provide inpatient hospital services;
   b. make cash payments to intended recipients of health services;
   c. purchase or improve land, purchase, construct or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment - unless the State of Rhode Island has obtained a waiver from the cognizant federal agency;
   d. satisfy any requirement for the expenditure of non-federal funds as a condition for the receipt of federal funds without the prior approval of the Department;
   e. provide financial assistance to any entity other than a public or nonprofit entity;

f. provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs, unless the Surgeon General of the United States determines that a demonstration needle exchange program would be effective in reducing drug abuse and the risk that the public will become infected with the etiologic agent for acquired immune deficiency syndrome;
g. carry out any testing for the etiologic agent for Acquired Immune Deficiency Syndrome unless such testing is accompanied by appropriate pre-test counseling and appropriate post-test counseling;
h. None of the funds provided under this Agreement may be used to pay the salary of an individual at a rate in excess of Level II of the federal Executive Pay Schedule.

B. Treatment Programs

1. Funding under this initiative shall not be utilized to treat individuals who are insured for service through private health insurance or other public programs, including Title 19, RIte Care, health care benefits available to veterans, or for individuals who have the ability to pay for service. Admission into state funded treatment will be prioritized in the following descending order:
   a. pregnant injecting drug users;
   b. pregnant women;
   c. injecting drug users;
   d. persons who are HIV antibody positive or have HIV disease;
   e. Treatment Accountability for Safer Communities (TASC) referred clients
   f. parents who are involved with the Department for Children, Youth and Families (DCYF) and are working toward reunification with their children, and whose participation in substance abuse treatment is a prerequisite for reunification;
   g. persons who while incarcerated began substance abuse treatment and continue to require additional treatment after release from prison.

2. Target Population: The eligible population for this initiative includes all medically uninsured Rhode Islanders with incomes up to 200% of the federal poverty level* who are determined to be in need of Level I and II services, utilizing ASAM PPC-2R criteria as the basis for determining needed level of care.

**Income is defined as total household income less the following deductions: a) Documented Court Ordered Payments (Alimony and/or Child Support); and b) Documented Medical Expenditures: including out-of-pocket medical costs, to include medical insurance costs – premiums, deductibles and co-payments. In order to qualify for a deduction, the client must produce documentation demonstrating payment. If there is no documentation of payment, the expenditure can be recognized as a deduction in determining financial eligibility, or for co-payment determination, for a thirty-day period. If after thirty days the documentation is still not provided, the deduction can no longer be recognized. Financial eligibility must be reassessed every 90 days.*

3. Make available tuberculosis ("TB"), Hepatitis C (HCV), Human Immunodeficiency Virus (HIV), and sexually transmitted disease (STD) services directly or through arrangements with other public or nonprofit private entities to all individuals receiving treatment for substance abuse. Services shall include counseling; testing to determine whether the individual has been infected with mycobacterium tuberculosis to determine the appropriate form of treatment, and referral of individuals infected by TB for appropriate medical evaluation and treatment.

4. When serving pregnant women or women/men with dependent children, provide or arrange for the following services:
   a. primary medical care for women/men, including referral of women for prenatal care and, while the client is receiving such services, child care;
   b. primary pediatric care, including immunization, for their children;
   c. gender specific substance abuse treatment and other therapeutic interventions shall address issues of relationships, life skill building, sexual abuse, physical abuse and parenting. While

the clients are receiving these services, child care shall be provided or arranged for;
d. therapeutic interventions for children in custody of women/men in treatment (shall include developmental needs, issues of sexual and physical abuse/neglect);
e. case management and transportation to ensure that women/men and their children have access to the above mentioned services.

5. When treating individuals for injection drug use, upon reaching ninety (90) percent of its capacity to admit individuals to the program, the Provider shall notify the Department through its Division of Behavioral Healthcare (DBH) of that fact within seven (7) days. Providers shall make every attempt to admit individuals in need of treatment for injection drug use within fourteen (14) days after making the request for admission to the program, or one hundred and twenty (120) days after the date of request if interim services are provided. Interim services shall include:

   a. counseling and education about Human Immunodeficiency Virus (HIV), Hepatitis C (HCV), sexually transmitted disease (STD), and Tuberculosis (TB), about risks of needle-sharing, risks of transmission to sexual partners and infants and about steps that can be taken to ensure that HIV, HCV, STD, and TB transmission does not occur;
   b. referral for HIV, HCV, STD or TB treatment services, if necessary;
   c. for pregnant women, interim services shall include referral for prenatal care and education regarding the effects of substance abuse on the fetus;
   d. the Provider shall maintain a record of individuals who have received interim services. The documentation should include client's name, address, dates and types of service(s) they have received;
   e. the Provider shall maintain a waiting list for all such clients awaiting treatment. This list shall be made available to DBH upon request.

6. Use the current edition of the American Society of Addiction Medicine Patient Placement Criteria or a substantially equivalent Division of Behavioral Health reviewed/approved tool for determining client placement, continued stay and discharge for all clients who are covered under this contract or by Medicaid.

7. Completion of a comprehensive bio-psychosocial assessment designed to determine client readiness for treatment, diagnosis (utilizing the latest version of the Diagnostic and Statistical Manual of Mental Disorders (DSM)), substance abuse history, appropriateness for treatment, and need for other supports to attain and maintain sobriety.

8. Provide mental health / psychiatric treatment services to address the treatment needs of clients with mental health / psychiatric symptoms or diagnoses. Psychiatric services shall be available either on site or by referral.

9. The Program must be accessible and must either directly or through arrangements provide programmatically accessible services for individuals with physical or other disabilities. The access and referral mechanism must also accommodate cultural and linguistic minorities, and clients with mobility or other conditions, as mandated by ADA.

10. The Program must either directly or, through arrangements, provide for culturally competent services to cultural and linguistic minorities.

11. Urinalysis or Breathalyzer screening. Each client will receive a minimum of one random supervised 5-panel urine screen per week for first 90 days of treatment; unless it is clinically determined otherwise. Toxicology screens are to be continued throughout treatment with documentation of clinical necessary. The cost of additional urine toxicology screens requested or required by DCYF, Courts, other Criminal Justice or other entities that are not part of the substance abuse treatment plan for financially eligible clients served under this agreement shall not be charged to the client, but may be charged to the entity requesting or requiring the screen. Screening is not to be considered a counseling session.

12. Case Management services. Includes securing the linkage and coordination of services throughout the course of treatment. Services may include, but are not limited to:

    a. housing, vocational, legal and educational services;
    b. the provision of or arranging of childcare;

c. coordination with other systems which share program services for the client population. Such agencies include, but are not limited to, child welfare services, the criminal justice system, public welfare agencies, elder services, and health care.

13. Aftercare/Continuing Care. Each client must have a continuing care plan established. The plan will include documentation of the type and location of services provided. Such services will enable the client to sustain abstinence and a recovery-oriented lifestyle. These services offer clients support and opportunity for further growth and development which may include but are not limited to case management, group or family support, advocacy, and outpatient services, as well as toxicology screens.

14. Relapse shall not be used as a reason for discharge. No otherwise eligible client shall be discharged or refused admission based on inability to pay. It is expected that a client's lack of attendance will be added to the Problem List and Treatment Plan, and clinically addressed, rather than using it as a punitive measure.

15. Follow-up after discharge at 1, 3 and 6-month intervals.

C. Outpatient Services

1. **Level I Outpatient Treatment.** Staff provide professionally directed evaluation, treatment and recovery services provided in regularly scheduled sessions of up to nine contact hours a week. Services are tailored to each patient's level of clinical severity and must address major lifestyle, attitudinal and behavioral issues that may impede the goals of treatment. Length of service will vary with the severity of the individual's illness and his/her response to treatment.

2. Rehabilitative Counseling Services:

   a. Topics shall include, but are not limited to:
      i. Substance abuse /dependency /recovery;
      ii. Information regarding self-help and other recovery support programs;
      iii. HV/STD, Tuberculosis and Hepatitis infection and risk reduction;
      iv. Relapse prevention;
      v. Recreation/life and social skill building;
      vi. Employment readiness;
      vii. Gender specific issues in addiction and recovery as well as trauma, abuse and grief issues;
      viii. Parenting issues (if applicable);
      ix. Continuing care / aftercare planning.

   b. Weekly Counseling Hours: each individual shall be provided for up to nine (9) hours per week, according to documented client need and application of ASAM criteria.
   c. Individual Counseling Session: individual and family counseling shall consist of 50 to 60-minute sessions and, in the case of family counseling, must include the primary client in the session. A minimum of at least one individual session per week for the first 60 days of treatment, more often if clinically appropriate, in addition to group sessions. Individual sessions to be continued throughout treatment as clinically appropriate.
   d. Group Counseling Session: group sessions shall contain a maximum of ten clients and shall be of 60 to 90 minutes in duration. Educational and recreational sessions may have more than ten participants.

D. Intensive Outpatient Treatment Services.

1. Level II.1, Intensive Outpatient Treatment. Intensive Outpatient treatment programs provide a minimum of nine hours to a maximum of nineteen hours of structured programming per week, consisting of comprehensive bio-psychosocial assessments, counseling, education and individualized treatment plans, which include problem formulation, treatment goals and measurable objectives in addition to affiliations with other levels of care to assist in accessing clinically necessary "wraparound" support services. Additionally, this level of care addresses the patient's needs for psychiatric and medical services through consultation or referral arrangements, and case management.

2. Program Requirements

   a. Minimum of 3-5 hours of program per day. (Time spent eating a meal is not included in this; however, up to 2, 15-minute breaks per day may be included. Meal planning and preparation may be included if this activity has a clear therapeutic goal, and is part of the client's treatment plan).
   b. Minimum of 3-5 days per week of programming (minimum of 9 hours per week).
   c. Minimum of 2 one-hour group therapy sessions per day. Maximum of ten clients per group therapy session. Educational and recreational sessions may have more participants.
   d. Minimum of 1 individual therapy session per week, minimum of 50-60 minutes duration.
   e. Family therapy sessions which involve family members, guardians, or significant others in the assessment treatment and continuing care of the client, if family exists and is willing and able to participate.
   f. Program allows time for parents to interact with children during course of day if children are in childcare on-site.
   g. Educational sessions including the following topics:

      i. Substance abuse/dependence/recovery
      ii. Information regarding Self-help programs and other outside resources
      iii. HIV/STD and Hepatitis infection and risk reduction
      iv. Relapse prevention
      v. Gender specific issues in addiction and recovery as well as trauma, abuse and grief issues
      vi. Parenting issues (if applicable)

   h. The initial treatment plan will be completed within 14 days of admission, reviewed at least weekly and revised as goals are accomplished or new treatment issues arise. If an individual has been referred from a higher level of care, the referring agency's treatment plan may be utilized on a preliminary basis.

E. Day/PHP Treatment Services

1. Level II.5, Partial Hospitalization/Day Treatment. At least 20 hours of skilled treatment services are provided each week. These services may include individual and group counseling, family therapy, educational groups, occupational and recreational therapy, psychotherapy, or other therapies. These are provided in the amounts, frequency and intensity appropriate to address the objectives of the patient's treatment plan.

2. Program Specifications.

   a. Minimum of 4-5 hours of program per day, and a minimum of 20 hours per week. (Time spent eating a meal is not included in this; however, up to 2, 15-minute breaks per day may be included. Meal planning and preparation may be included if this activity has a clear therapeutic goal, and is part of the client's treatment plan).
   b. Minimum of 4-5 days per week of programming (minimum of 20 hours per week).
   c. Minimum of 2 one-hour group therapy sessions per day. Maximum of ten clients per group therapy session. Educational and recreational sessions may have more participants.
   d. Minimum of 1 individual therapy session per week, minimum of 50-60 minutes duration.
   e. Family therapy sessions which involve family members, guardians, or significant others in the assessment treatment and continuing care of the client, if family exists and is willing and able to participate.
   f. Program allows time for parents to interact with children during course of day if children are in childcare on-site.
   g. Educational sessions including the following topics:

      i. Substance abuse/dependence/recovery
      ii. Information regarding Self-help programs
      iii. HIV/STD and Hepatitis infection and risk reduction
      iv. Relapse prevention
      v. Gender specific issues in addiction and recovery, as well as trauma, abuse, and grief issues

vi. Parenting issues (if applicable)

h. The initial treatment plan will be completed within 14 days of admission, reviewed at least weekly and revised as goals are accomplished or new treatment issues arise. If an individual has been referred from a higher level of care, the referring agency's treatment plan may be utilized on a preliminary basis.

GOAL # 14

-- An agreement to ensure that no program funded through the block grant will use funds to provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs (See 42 U.S.C. 300x-31(a)(1)(F) and 45 C.F.R. 96.135(a)(6)).

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In FFY2007, the state will:

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A. General Requirements - All Treatment Services Contract Language

1. The provider agrees to utilize any standardized assessment instrument, as well as outcome measurement instruments, which may be adopted by the Department during the contract period.
2. The Provider shall provide continuing education for its employees.
3. The Provider agrees to carry on outreach activities for the purpose of encouraging people in need of treatment to seek assistance.
4. Prohibited Use of Funds:
   a. provide inpatient hospital services;
   b. make cash payments to intended recipients of health services;
   c. purchase or improve land, purchase, construct or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment - unless the State of Rhode Island has obtained a waiver from the cognizant federal agency;
   d. satisfy any requirement for the expenditure of non-federal funds as a condition for the receipt of federal funds without the prior approval of the Department;
   e. provide financial assistance to any entity other than a public or nonprofit entity;

f. provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs, unless the Surgeon General of the United States determines that a demonstration needle exchange program would be effective in reducing drug abuse and the risk that the public will become infected with the etiologic agent for acquired immune deficiency syndrome;
g. carry out any testing for the etiologic agent for Acquired Immune Deficiency Syndrome unless such testing is accompanied by appropriate pre-test counseling and appropriate post-test counseling;
h. None of the funds provided under this Agreement may be used to pay the salary of an individual at a rate in excess of Level II of the federal Executive Pay Schedule.

B. Treatment Programs

1. Funding under this initiative shall not be utilized to treat individuals who are insured for service through private health insurance or other public programs, including Title 19, RIte Care, health care benefits available to veterans, or for individuals who have the ability to pay for service. Admission into state funded treatment will be prioritized in the following descending order:
   a. pregnant injecting drug users;
   b. pregnant women;
   c. injecting drug users;
   d. persons who are HIV antibody positive or have HIV disease;
   e. Treatment Accountability for Safer Communities (TASC) referred clients
   f. parents who are involved with the Department for Children, Youth and Families (DCYF) and are working toward reunification with their children, and whose participation in substance abuse treatment is a prerequisite for reunification;
   g. persons who while incarcerated began substance abuse treatment and continue to require additional treatment after release from prison.

2. Target Population: The eligible population for this initiative includes all medically uninsured Rhode Islanders with incomes up to 200% of the federal poverty level* who are determined to be in need of Level I and II services, utilizing ASAM PPC-2R criteria as the basis for determining needed level of care.

**Income is defined as total household income less the following deductions: a) Documented Court Ordered Payments (Alimony and/or Child Support); and b) Documented Medical Expenditures: including out-of-pocket medical costs, to include medical insurance costs – premiums, deductibles and co-payments. In order to qualify for a deduction, the client must produce documentation demonstrating payment. If there is no documentation of payment, the expenditure can be recognized as a deduction in determining financial eligibility, or for co-payment determination, for a thirty-day period. If after thirty days the documentation is still not provided, the deduction can no longer be recognized. Financial eligibility must be reassessed every 90 days.*

3. Make available tuberculosis ("TB"), Hepatitis C (HCV), Human Immunodeficiency Virus (HIV), and sexually transmitted disease (STD) services directly or through arrangements with other public or nonprofit private entities to all individuals receiving treatment for substance abuse. Services shall include counseling; testing to determine whether the individual has been infected with mycobacterium tuberculosis to determine the appropriate form of treatment, and referral of individuals infected by TB for appropriate medical evaluation and treatment.

4. When serving pregnant women or women/men with dependent children, provide or arrange for the following services:
   a. primary medical care for women/men, including referral of women for prenatal care and, while the client is receiving such services, child care;
   b. primary pediatric care, including immunization, for their children;
   c. gender specific substance abuse treatment and other therapeutic interventions shall address issues of relationships, life skill building, sexual abuse, physical abuse and parenting. While

the clients are receiving these services, child care shall be provided or arranged for;
d. therapeutic interventions for children in custody of women/men in treatment (shall include developmental needs, issues of sexual and physical abuse/neglect);
e. case management and transportation to ensure that women/men and their children have access to the above mentioned services.

5. When treating individuals for injection drug use, upon reaching ninety (90) percent of its capacity to admit individuals to the program, the Provider shall notify the Department through its Division of Behavioral Healthcare (DBH) of that fact within seven (7) days. Providers shall make every attempt to admit individuals in need of treatment for injection drug use within fourteen (14) days after making the request for admission to the program, or one hundred and twenty (120) days after the date of request if interim services are provided. Interim services shall include:

   a. counseling and education about Human Immunodeficiency Virus (HIV), Hepatitis C (HCV), sexually transmitted disease (STD), and Tuberculosis (TB), about risks of needle-sharing, risks of transmission to sexual partners and infants and about steps that can be taken to ensure that HIV, HCV, STD, and TB transmission does not occur;
   b. referral for HIV, HCV, STD or TB treatment services, if necessary;
   c. for pregnant women, interim services shall include referral for prenatal care and education regarding the effects of substance abuse on the fetus;
   d. the Provider shall maintain a record of individuals who have received interim services. The documentation should include client's name, address, dates and types of service(s) they have received;
   e. the Provider shall maintain a waiting list for all such clients awaiting treatment. This list shall be made available to DBH upon request.

6. Use the current edition of the American Society of Addiction Medicine Patient Placement Criteria or a substantially equivalent Division of Behavioral Health reviewed/approved tool for determining client placement, continued stay and discharge for all clients who are covered under this contract or by Medicaid.

7. Completion of a comprehensive bio-psychosocial assessment designed to determine client readiness for treatment, diagnosis (utilizing the latest version of the Diagnostic and Statistical Manual of Mental Disorders (DSM)), substance abuse history, appropriateness for treatment, and need for other supports to attain and maintain sobriety.

8. Provide mental health / psychiatric treatment services to address the treatment needs of clients with mental health / psychiatric symptoms or diagnoses. Psychiatric services shall be available either on site or by referral.

9. The Program must be accessible and must either directly or through arrangements provide programmatically accessible services for individuals with physical or other disabilities. The access and referral mechanism must also accommodate cultural and linguistic minorities, and clients with mobility or other conditions, as mandated by ADA.

10. The Program must either directly or, through arrangements, provide for culturally competent services to cultural and linguistic minorities.

11. Urinalysis or Breathalyzer screening. Each client will receive a minimum of one random supervised 5-panel urine screen per week for first 90 days of treatment; unless it is clinically determined otherwise. Toxicology screens are to be continued throughout treatment with documentation of clinical necessary. The cost of additional urine toxicology screens requested or required by DCYF, Courts, other Criminal Justice or other entities that are not part of the substance abuse treatment plan for financially eligible clients served under this agreement shall not be charged to the client, but may be charged to the entity requesting or requiring the screen. Screening is not to be considered a counseling session.

12. Case Management services. Includes securing the linkage and coordination of services throughout the course of treatment. Services may include, but are not limited to:

    a. housing, vocational, legal and educational services;
    b. the provision of or arranging of childcare;

c. coordination with other systems which share program services for the client population. Such agencies include, but are not limited to, child welfare services, the criminal justice system, public welfare agencies, elder services, and health care.

13. Aftercare/Continuing Care. Each client must have a continuing care plan established. The plan will include documentation of the type and location of services provided. Such services will enable the client to sustain abstinence and a recovery-oriented lifestyle. These services offer clients support and opportunity for further growth and development which may include but are not limited to case management, group or family support, advocacy, and outpatient services, as well as toxicology screens.

14. Relapse shall not be used as a reason for discharge. No otherwise eligible client shall be discharged or refused admission based on inability to pay. It is expected that a client's lack of attendance will be added to the Problem List and Treatment Plan, and clinically addressed, rather than using it as a punitive measure.

15. Follow-up after discharge at 1, 3 and 6-month intervals.

C. Outpatient Services

1. **Level I Outpatient Treatment.** Staff provide professionally directed evaluation, treatment and recovery services provided in regularly scheduled sessions of up to nine contact hours a week. Services are tailored to each patient's level of clinical severity and must address major lifestyle, attitudinal and behavioral issues that may impede the goals of treatment. Length of service will vary with the severity of the individual's illness and his/her response to treatment.

2. Rehabilitative Counseling Services:

   a. Topics shall include, but are not limited to:
      i. Substance abuse /dependency /recovery;
      ii. Information regarding self-help and other recovery support programs;
      iii. HV/STD, Tuberculosis and Hepatitis infection and risk reduction;
      iv. Relapse prevention;
      v. Recreation/life and social skill building;
      vi. Employment readiness;
      vii. Gender specific issues in addiction and recovery as well as trauma, abuse and grief issues;
      viii. Parenting issues (if applicable);
      ix. Continuing care / aftercare planning.

   b. Weekly Counseling Hours: each individual shall be provided for up to nine (9) hours per week, according to documented client need and application of ASAM criteria.
   c. Individual Counseling Session: individual and family counseling shall consist of 50 to 60-minute sessions and, in the case of family counseling, must include the primary client in the session. A minimum of at least one individual session per week for the first 60 days of treatment, more often if clinically appropriate, in addition to group sessions. Individual sessions to be continued throughout treatment as clinically appropriate.
   d. Group Counseling Session: group sessions shall contain a maximum of ten clients and shall be of 60 to 90 minutes in duration. Educational and recreational sessions may have more than ten participants.

D. Intensive Outpatient Treatment Services.

1. Level II.1, Intensive Outpatient Treatment. Intensive Outpatient treatment programs provide a minimum of nine hours to a maximum of nineteen hours of structured programming per week, consisting of comprehensive bio-psychosocial assessments, counseling, education and individualized treatment plans, which include problem formulation, treatment goals and measurable objectives in addition to affiliations with other levels of care to assist in accessing clinically necessary "wraparound" support services. Additionally, this level of care addresses the patient's needs for psychiatric and medical services through consultation or referral arrangements, and case management.

2. Program Requirements

   a. Minimum of 3-5 hours of program per day. (Time spent eating a meal is not included in this; however, up to 2, 15-minute breaks per day may be included. Meal planning and preparation may be included if this activity has a clear therapeutic goal, and is part of the client's treatment plan).
   b. Minimum of 3-5 days per week of programming (minimum of 9 hours per week).
   c. Minimum of 2 one-hour group therapy sessions per day. Maximum of ten clients per group therapy session. Educational and recreational sessions may have more participants.
   d. Minimum of 1 individual therapy session per week, minimum of 50-60 minutes duration.
   e. Family therapy sessions which involve family members, guardians, or significant others in the assessment treatment and continuing care of the client, if family exists and is willing and able to participate.
   f. Program allows time for parents to interact with children during course of day if children are in childcare on-site.
   g. Educational sessions including the following topics:

      i. Substance abuse/dependence/recovery
      ii. Information regarding Self-help programs and other outside resources
      iii. HIV/STD and Hepatitis infection and risk reduction
      iv. Relapse prevention
      v. Gender specific issues in addiction and recovery as well as trauma, abuse and grief issues
      vi. Parenting issues (if applicable)

   h. The initial treatment plan will be completed within 14 days of admission, reviewed at least weekly and revised as goals are accomplished or new treatment issues arise. If an individual has been referred from a higher level of care, the referring agency's treatment plan may be utilized on a preliminary basis.

E. Day/PHP Treatment Services

1. Level II.5, Partial Hospitalization/Day Treatment. At least 20 hours of skilled treatment services are provided each week. These services may include individual and group counseling, family therapy, educational groups, occupational and recreational therapy, psychotherapy, or other therapies. These are provided in the amounts, frequency and intensity appropriate to address the objectives of the patient's treatment plan.

2. Program Specifications.

   a. Minimum of 4-5 hours of program per day, and a minimum of 20 hours per week. (Time spent eating a meal is not included in this; however, up to 2, 15-minute breaks per day may be included. Meal planning and preparation may be included if this activity has a clear therapeutic goal, and is part of the client's treatment plan).
   b. Minimum of 4-5 days per week of programming (minimum of 20 hours per week).
   c. Minimum of 2 one-hour group therapy sessions per day. Maximum of ten clients per group therapy session. Educational and recreational sessions may have more participants.
   d. Minimum of 1 individual therapy session per week, minimum of 50-60 minutes duration.
   e. Family therapy sessions which involve family members, guardians, or significant others in the assessment treatment and continuing care of the client, if family exists and is willing and able to participate.
   f. Program allows time for parents to interact with children during course of day if children are in childcare on-site.
   g. Educational sessions including the following topics:

      i. Substance abuse/dependence/recovery
      ii. Information regarding Self-help programs
      iii. HIV/STD and Hepatitis infection and risk reduction
      iv. Relapse prevention
      v. Gender specific issues in addiction and recovery, as well as trauma, abuse, and grief issues

vi. Parenting issues (if applicable)

h. The initial treatment plan will be completed within 14 days of admission, reviewed at least weekly and revised as goals are accomplished or new treatment issues arise. If an individual has been referred from a higher level of care, the referring agency's treatment plan may be utilized on a preliminary basis.

GOAL # 14

-- An agreement to ensure that no program funded through the block grant will use funds to provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs (See 42 U.S.C. 300x-31(a)(1)(F) and 45 C.F.R. 96.135(a)(6)).

FFY 2004 (Compliance):

FFY 2006 (Progress):

FFY 2007 (Intended Use):

GOAL # 14. An agreement to ensure that no program funded through the block grant will use funds to provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs.

In FFY2004, the state:

- Continued to include language in the contracts that prohibits this activity with federal dollars.

In FFY2006, the state:

- Continues to include language in the contracts that prohibits this activity with federal dollars.

In FFY2007, the state will:

- Continue to include language in the contracts that prohibits this activity with federal dollars.

A. General Requirements - All Treatment Services Contract Language

1. The provider agrees to utilize any standardized assessment instrument, as well as outcome measurement instruments, which may be adopted by the Department during the contract period.
2. The Provider shall provide continuing education for its employees.
3. The Provider agrees to carry on outreach activities for the purpose of encouraging people in need of treatment to seek assistance.
4. Prohibited Use of Funds:
   a. provide inpatient hospital services;
   b. make cash payments to intended recipients of health services;
   c. purchase or improve land, purchase, construct or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment - unless the State of Rhode Island has obtained a waiver from the cognizant federal agency;
   d. satisfy any requirement for the expenditure of non-federal funds as a condition for the receipt of federal funds without the prior approval of the Department;
   e. provide financial assistance to any entity other than a public or nonprofit entity;

f. provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs, unless the Surgeon General of the United States determines that a demonstration needle exchange program would be effective in reducing drug abuse and the risk that the public will become infected with the etiologic agent for acquired immune deficiency syndrome;
g. carry out any testing for the etiologic agent for Acquired Immune Deficiency Syndrome unless such testing is accompanied by appropriate pre-test counseling and appropriate post-test counseling;
h. None of the funds provided under this Agreement may be used to pay the salary of an individual at a rate in excess of Level II of the federal Executive Pay Schedule.

B. Treatment Programs

1. Funding under this initiative shall not be utilized to treat individuals who are insured for service through private health insurance or other public programs, including Title 19, RIte Care, health care benefits available to veterans, or for individuals who have the ability to pay for service. Admission into state funded treatment will be prioritized in the following descending order:
   a. pregnant injecting drug users;
   b. pregnant women;
   c. injecting drug users;
   d. persons who are HIV antibody positive or have HIV disease;
   e. Treatment Accountability for Safer Communities (TASC) referred clients
   f. parents who are involved with the Department for Children, Youth and Families (DCYF) and are working toward reunification with their children, and whose participation in substance abuse treatment is a prerequisite for reunification;
   g. persons who while incarcerated began substance abuse treatment and continue to require additional treatment after release from prison.

2. Target Population: The eligible population for this initiative includes all medically uninsured Rhode Islanders with incomes up to 200% of the federal poverty level* who are determined to be in need of Level I and II services, utilizing ASAM PPC-2R criteria as the basis for determining needed level of care.

**Income is defined as total household income less the following deductions: a) Documented Court Ordered Payments (Alimony and/or Child Support); and b) Documented Medical Expenditures: including out-of-pocket medical costs, to include medical insurance costs – premiums, deductibles and co-payments. In order to qualify for a deduction, the client must produce documentation demonstrating payment. If there is no documentation of payment, the expenditure can be recognized as a deduction in determining financial eligibility, or for co-payment determination, for a thirty-day period. If after thirty days the documentation is still not provided, the deduction can no longer be recognized. Financial eligibility must be reassessed every 90 days.*

3. Make available tuberculosis ("TB"), Hepatitis C (HCV), Human Immunodeficiency Virus (HIV), and sexually transmitted disease (STD) services directly or through arrangements with other public or nonprofit private entities to all individuals receiving treatment for substance abuse. Services shall include counseling; testing to determine whether the individual has been infected with mycobacterium tuberculosis to determine the appropriate form of treatment, and referral of individuals infected by TB for appropriate medical evaluation and treatment.

4. When serving pregnant women or women/men with dependent children, provide or arrange for the following services:
   a. primary medical care for women/men, including referral of women for prenatal care and, while the client is receiving such services, child care;
   b. primary pediatric care, including immunization, for their children;
   c. gender specific substance abuse treatment and other therapeutic interventions shall address issues of relationships, life skill building, sexual abuse, physical abuse and parenting. While

the clients are receiving these services, child care shall be provided or arranged for;
d. therapeutic interventions for children in custody of women/men in treatment (shall include developmental needs, issues of sexual and physical abuse/neglect);
e. case management and transportation to ensure that women/men and their children have access to the above mentioned services.

5. When treating individuals for injection drug use, upon reaching ninety (90) percent of its capacity to admit individuals to the program, the Provider shall notify the Department through its Division of Behavioral Healthcare (DBH) of that fact within seven (7) days. Providers shall make every attempt to admit individuals in need of treatment for injection drug use within fourteen (14) days after making the request for admission to the program, or one hundred and twenty (120) days after the date of request if interim services are provided. Interim services shall include:

   a. counseling and education about Human Immunodeficiency Virus (HIV), Hepatitis C (HCV), sexually transmitted disease (STD), and Tuberculosis (TB), about risks of needle-sharing, risks of transmission to sexual partners and infants and about steps that can be taken to ensure that HIV, HCV, STD, and TB transmission does not occur;
   b. referral for HIV, HCV, STD or TB treatment services, if necessary;
   c. for pregnant women, interim services shall include referral for prenatal care and education regarding the effects of substance abuse on the fetus;
   d. the Provider shall maintain a record of individuals who have received interim services. The documentation should include client's name, address, dates and types of service(s) they have received;
   e. the Provider shall maintain a waiting list for all such clients awaiting treatment. This list shall be made available to DBH upon request.

6. Use the current edition of the American Society of Addiction Medicine Patient Placement Criteria or a substantially equivalent Division of Behavioral Health reviewed/approved tool for determining client placement, continued stay and discharge for all clients who are covered under this contract or by Medicaid.

7. Completion of a comprehensive bio-psychosocial assessment designed to determine client readiness for treatment, diagnosis (utilizing the latest version of the Diagnostic and Statistical Manual of Mental Disorders (DSM)), substance abuse history, appropriateness for treatment, and need for other supports to attain and maintain sobriety.

8. Provide mental health / psychiatric treatment services to address the treatment needs of clients with mental health / psychiatric symptoms or diagnoses. Psychiatric services shall be available either on site or by referral.

9. The Program must be accessible and must either directly or through arrangements provide programmatically accessible services for individuals with physical or other disabilities. The access and referral mechanism must also accommodate cultural and linguistic minorities, and clients with mobility or other conditions, as mandated by ADA.

10. The Program must either directly or, through arrangements, provide for culturally competent services to cultural and linguistic minorities.

11. Urinalysis or Breathalyzer screening. Each client will receive a minimum of one random supervised 5-panel urine screen per week for first 90 days of treatment; unless it is clinically determined otherwise. Toxicology screens are to be continued throughout treatment with documentation of clinical necessary. The cost of additional urine toxicology screens requested or required by DCYF, Courts, other Criminal Justice or other entities that are not part of the substance abuse treatment plan for financially eligible clients served under this agreement shall not be charged to the client, but may be charged to the entity requesting or requiring the screen. Screening is not to be considered a counseling session.

12. Case Management services. Includes securing the linkage and coordination of services throughout the course of treatment. Services may include, but are not limited to:

    a. housing, vocational, legal and educational services;
    b. the provision of or arranging of childcare;

c. coordination with other systems which share program services for the client population. Such agencies include, but are not limited to, child welfare services, the criminal justice system, public welfare agencies, elder services, and health care.

13. Aftercare/Continuing Care. Each client must have a continuing care plan established. The plan will include documentation of the type and location of services provided. Such services will enable the client to sustain abstinence and a recovery-oriented lifestyle. These services offer clients support and opportunity for further growth and development which may include but are not limited to case management, group or family support, advocacy, and outpatient services, as well as toxicology screens.

14. Relapse shall not be used as a reason for discharge. No otherwise eligible client shall be discharged or refused admission based on inability to pay. It is expected that a client's lack of attendance will be added to the Problem List and Treatment Plan, and clinically addressed, rather than using it as a punitive measure.

15. Follow-up after discharge at 1, 3 and 6-month intervals.

C. Outpatient Services

1. **Level I Outpatient Treatment.** Staff provide professionally directed evaluation, treatment and recovery services provided in regularly scheduled sessions of up to nine contact hours a week. Services are tailored to each patient's level of clinical severity and must address major lifestyle, attitudinal and behavioral issues that may impede the goals of treatment. Length of service will vary with the severity of the individual's illness and his/her response to treatment.

2. Rehabilitative Counseling Services:

a. Topics shall include, but are not limited to:
   i. Substance abuse /dependency /recovery;
   ii. Information regarding self-help and other recovery support programs;
   iii. HV/STD, Tuberculosis and Hepatitis infection and risk reduction;
   iv. Relapse prevention;
   v. Recreation/life and social skill building;
   vi. Employment readiness;
   vii. Gender specific issues in addiction and recovery as well as trauma, abuse and grief issues;
   viii. Parenting issues (if applicable);
   ix. Continuing care / aftercare planning.

b. Weekly Counseling Hours: each individual shall be provided for up to nine (9) hours per week, according to documented client need and application of ASAM criteria.
c. Individual Counseling Session: individual and family counseling shall consist of 50 to 60-minute sessions and, in the case of family counseling, must include the primary client in the session. A minimum of at least one individual session per week for the first 60 days of treatment, more often if clinically appropriate, in addition to group sessions. Individual sessions to be continued throughout treatment as clinically appropriate.
d. Group Counseling Session: group sessions shall contain a maximum of ten clients and shall be of 60 to 90 minutes in duration. Educational and recreational sessions may have more than ten participants.

D. Intensive Outpatient Treatment Services.

1. Level II.1, Intensive Outpatient Treatment. Intensive Outpatient treatment programs provide a minimum of nine hours to a maximum of nineteen hours of structured programming per week, consisting of comprehensive bio-psychosocial assessments, counseling, education and individualized treatment plans, which include problem formulation, treatment goals and measurable objectives in addition to affiliations with other levels of care to assist in accessing clinically necessary "wraparound" support services. Additionally, this level of care addresses the patient's needs for psychiatric and medical services through consultation or referral arrangements, and case management.

2. Program Requirements

   a. Minimum of 3-5 hours of program per day. (Time spent eating a meal is not included in this; however, up to 2, 15-minute breaks per day may be included. Meal planning and preparation may be included if this activity has a clear therapeutic goal, and is part of the client's treatment plan).
   b. Minimum of 3-5 days per week of programming (minimum of 9 hours per week).
   c. Minimum of 2 one-hour group therapy sessions per day. Maximum of ten clients per group therapy session. Educational and recreational sessions may have more participants.
   d. Minimum of 1 individual therapy session per week, minimum of 50-60 minutes duration.
   e. Family therapy sessions which involve family members, guardians, or significant others in the assessment treatment and continuing care of the client, if family exists and is willing and able to participate.
   f. Program allows time for parents to interact with children during course of day if children are in childcare on-site.
   g. Educational sessions including the following topics:

      i. Substance abuse/dependence/recovery
      ii. Information regarding Self-help programs and other outside resources
      iii. HIV/STD and Hepatitis infection and risk reduction
      iv. Relapse prevention
      v. Gender specific issues in addiction and recovery as well as trauma, abuse and grief issues
      vi. Parenting issues (if applicable)

   h. The initial treatment plan will be completed within 14 days of admission, reviewed at least weekly and revised as goals are accomplished or new treatment issues arise. If an individual has been referred from a higher level of care, the referring agency's treatment plan may be utilized on a preliminary basis.

E. Day/PHP Treatment Services

1. Level II.5, Partial Hospitalization/Day Treatment. At least 20 hours of skilled treatment services are provided each week. These services may include individual and group counseling, family therapy, educational groups, occupational and recreational therapy, psychotherapy, or other therapies. These are provided in the amounts, frequency and intensity appropriate to address the objectives of the patient's treatment plan.

2. Program Specifications.

   a. Minimum of 4-5 hours of program per day, and a minimum of 20 hours per week. (Time spent eating a meal is not included in this; however, up to 2, 15-minute breaks per day may be included. Meal planning and preparation may be included if this activity has a clear therapeutic goal, and is part of the client's treatment plan).
   b. Minimum of 4-5 days per week of programming (minimum of 20 hours per week).
   c. Minimum of 2 one-hour group therapy sessions per day. Maximum of ten clients per group therapy session. Educational and recreational sessions may have more participants.
   d. Minimum of 1 individual therapy session per week, minimum of 50-60 minutes duration.
   e. Family therapy sessions which involve family members, guardians, or significant others in the assessment treatment and continuing care of the client, if family exists and is willing and able to participate.
   f. Program allows time for parents to interact with children during course of day if children are in childcare on-site.
   g. Educational sessions including the following topics:

      i. Substance abuse/dependence/recovery
      ii. Information regarding Self-help programs
      iii. HIV/STD and Hepatitis infection and risk reduction
      iv. Relapse prevention
      v. Gender specific issues in addiction and recovery, as well as trauma, abuse, and grief issues

vi. Parenting issues (if applicable)

h. The initial treatment plan will be completed within 14 days of admission, reviewed at least weekly and revised as goals are accomplished or new treatment issues arise. If an individual has been referred from a higher level of care, the referring agency's treatment plan may be utilized on a preliminary basis.

Goal #14: Hypodermic Needle Program Footnotes
A. General Requirements - All Treatment Services Contract Language

1. The provider agrees to utilize any standardized assessment instrument, as well as outcome measurement instruments, which may be adopted by the Department during the contract period.

2. The Provider shall provide continuing education for its employees.

3. The Provider agrees to carry on outreach activities for the purpose of encouraging people in need of treatment to seek assistance.

4. Prohibited Use of Funds:

a. provide inpatient hospital services;
b. make cash payments to intended recipients of health services;
c. purchase or improve land, purchase, construct or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment unless the State of Rhode Island has obtained a waiver from the cognizant federal agency;
d. satisfy any requirement for the expenditure of non-federal funds as a condition for the receipt of federal funds without the prior approval of the Department;
e. provide financial assistance to any entity other than a public or nonprofit entity;
f. provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs, unless the Surgeon General of the United States determines that a demonstration needle exchange program would be effective in reducing drug abuse and the risk that the public will become infected with the etiologic agent for acquired immune deficiency syndrome;
g. carry out any testing for the etiologic agent for Acquired Immune Deficiency Syndrome unless such testing is accompanied by appropriate pre test counseling and appropriate post test counseling;
h. None of the funds provided under this Agreement may be used to pay the salary of an individual at a rate in excess of Level II of the federal Executive Pay Schedule.

B. Treatment Programs

1. Funding under this initiative shall not be utilized to treat individuals who are insured for service through private health insurance or other public programs, including Title 19, RIte Care, health care benefits available to veterans, or for individuals who have the ability to pay for service. Admission into state funded treatment will be prioritized in the following descending order:
a. pregnant injecting drug users;
b. pregnant women;
c. injecting drug users;
d. persons who are HIV antibody positive or have HIV disease;
e. Treatment Accountability for Safer Communities (TASC) referred clients
f. parents who are involved with the Department for Children, Youth and Families (DCYF) and are working toward reunification with their children, and whose participation in substance abuse treatment is a prerequisite for reunification;
g. persons who while incarcerated began substance abuse treatment and continue to require additional treatment after release from prison.

2. Target Population: The eligible population for this initiative includes all medically uninsured Rhode Islanders with incomes up to 200% of the federal poverty level* who are determined to be in need of Level I and II services, utilizing ASAM PPC-2R criteria as the basis for determining needed level of care.

Goal #14: Hypodermic Needle Program Footnotes
*Income is defined as total household income less the following deductions: a) Documented Court Ordered Payments (Alimony and/or Child Support); and b) Documented Medical Expenditures: including out-of-pocket medical costs, to include medical insurance costs – premiums, deductibles and co-payments. In order to qualify for a deduction, the client must produce documentation demonstrating payment. If there is no documentation of payment, the expenditure can be recognized as a deduction in determining financial eligibility, or for co-payment determination, for a thirty-day period. If after thirty days the documentation is still not provided, the deduction can no longer be recognized. Financial eligibility must be reassessed every 90 days.

3. Make available tuberculosis ("TB"), Hepatitis C (HCV), Human Immunodeficiency Virus (HIV), and sexually transmitted disease (STD) services directly or through arrangements with other public or nonprofit private entities to all individuals receiving treatment for substance abuse. Services shall include counseling; testing to determine whether the individual has been infected with mycobacterium tuberculosis to determine the appropriate form of treatment, and referral of individuals infected by TB for appropriate medical evaluation and treatment.

4. When serving pregnant women or women/men with dependent children, provide or arrange for the following services:
a. primary medical care for women/men, including referral of women for prenatal care and, while the client is receiving such services, child care;
b. primary pediatric care, including immunization, for their children;
c. gender specific substance abuse treatment and other therapeutic interventions shall address issues of relationships, life skill building, sexual abuse, physical abuse and parenting. While the clients are receiving these services, child care shall be provided or arranged for;
d. therapeutic interventions for children in custody of women/men in treatment (shall include developmental needs, issues of sexual and physical abuse/neglect);
e. case management and transportation to ensure that women/men and their children have access to the above mentioned services.

5. When treating individuals for injection drug use, upon reaching ninety (90) percent of its capacity to admit individuals to the program, the Provider shall notify the Department through its Division of Behavioral Healthcare (DBH) of that fact within seven (7) days. Providers shall make every attempt to admit individuals in need of treatment for injection drug use within fourteen (14) days after making the request for admission to the program, or one hundred and twenty (120) days after the date of request if interim services are provided. Interim services shall include:

a. counseling and education about Human Immunodeficiency Virus (HIV), Hepatitis C (HCV), sexually transmitted disease (STD), and Tuberculosis (TB), about risks of needle sharing, risks of transmission to sexual partners and infants and about steps that can be taken to ensure that HIV, HCV, STD, and TB transmission does not occur;
b. referral for HIV, HCV, STD or TB treatment services, if necessary;
c. for pregnant women, interim services shall include referral for prenatal care and education regarding the effects of substance abuse on the fetus;
d. the Provider shall maintain a record of individuals who have received interim services. The documentation should include client's name, address, dates and types of service(s) they have received;
e. the Provider shall maintain a waiting list for all such clients awaiting treatment. This list shall be made available to DBH upon request.

6. Use the current edition of the American Society of Addiction Medicine Patient Placement Criteria or a substantially equivalent Division of Behavioral Health reviewed/approved tool for determining client placement, continued stay

and discharge for all clients who are covered under this contract or by Medicaid.

7. Completion of a comprehensive bio-psychosocial assessment designed to determine client readiness for treatment, diagnosis (utilizing the latest version of the Diagnostic and Statistical Manual of Mental Disorders (DSM)), substance abuse history, appropriateness for treatment, and need for other supports to attain and maintain sobriety.

8. Provide mental health / psychiatric treatment services to address the treatment needs of clients with mental health / psychiatric symptoms or diagnoses. Psychiatric services shall be available either on site or by referral.

9. The Program must be accessible and must either directly or through arrangements provide programmatically accessible services for individuals with physical or other disabilities. The access and referral mechanism must also accommodate cultural and linguistic minorities, and clients with mobility or other conditions, as mandated by ADA.

10. The Program must either directly or, through arrangements, provide for culturally competent services to cultural and linguistic minorities.

11. Urinalysis or Breathalyzer screening. Each client will receive a minimum of one random supervised 5-panel urine screen per week for first 90 days of treatment; unless it is clinically determined otherwise. Toxicology screens are to be continued throughout treatment with documentation of clinical necessary. The cost of additional urine toxicology screens requested or required by DCYF, Courts, other Criminal Justice or other entities that are not part of the substance abuse treatment plan for financially eligible clients served under this agreement shall not be charged to the client, but may be charged to the entity requesting or requiring the screen. Screening is not to be considered a counseling session.

12. Case Management services. Includes securing the linkage and coordination of services throughout the course of treatment. Services may include, but are not limited to:

a. housing, vocational, legal and educational services;
b. the provision of or arranging of childcare;
c. coordination with other systems which share program services for the client population. Such agencies include, but are not limited to, child welfare services, the criminal justice system, public welfare agencies, elder services, and health care.

13. Aftercare/Continuing Care. Each client must have a continuing care plan established. The plan will include documentation of the type and location of services provided. Such services will enable the client to sustain abstinence and a recovery-oriented lifestyle. These services offer clients support and opportunity for further growth and development which may include but are not limited to case management, group or family support, advocacy, and outpatient services, as well as toxicology screens.

14. Relapse shall not be used as a reason for discharge. No otherwise eligible client shall be discharged or refused admission based on inability to pay. It is expected that a client’s lack of attendance will be added to the Problem List and Treatment Plan, and clinically addressed, rather than using it as a punitive measure.

15. Follow-up after discharge at 1, 3 and 6-month intervals.

C. Outpatient Services

Goal #14: Hypodermic Needle Program Footnotes

1. Level I Outpatient Treatment. Staff provide professionally directed evaluation, treatment and recovery services provided in regularly scheduled sessions of up to nine contact hours a week. Services are tailored to each patient's level of clinical severity and must address major lifestyle, attitudinal and behavioral issues that may impede the goals of treatment. Length of service will vary with the severity of the individual's illness and his/her response to treatment.

2. Rehabilitative Counseling Services:

a. Topics shall include, but are not limited to:
i. Substance abuse /dependency /recovery;
ii. Information regarding self-help and other recovery support programs;
iii. HV/STD, Tuberculosis and Hepatitis infection and risk reduction;
iv. Relapse prevention;
v. Recreation/life and social skill building;
vi. Employment readiness;
vii. Gender specific issues in addiction and recovery as well as trauma, abuse and grief issues;
viii. Parenting issues (if applicable);
ix. Continuing care / aftercare planning.

b. Weekly Counseling Hours: each individual shall be provided for up to nine (9) hours per week, according to documented client need and application of ASAM criteria.
c. Individual Counseling Session: individual and family counseling shall consist of 50 to 60-minute sessions and, in the case of family counseling, must include the primary client in the session. A minimum of at least one individual session per week for the first 60 days of treatment, more often if clinically appropriate, in addition to group sessions. Individual sessions to be continued throughout treatment as clinically appropriate.
d. Group Counseling Session: group sessions shall contain a maximum of ten clients and shall be of 60 to 90 minutes in duration. Educational and recreational sessions may have more than ten participants.

D. Intensive Outpatient Treatment Services.

1. Level II.1, Intensive Outpatient Treatment. Intensive Outpatient treatment programs provide a minimum of nine hours to a maximum of nineteen hours of structured programming per week, consisting of comprehensive bio-psychosocial assessments, counseling, education and individualized treatment plans, which include problem formulation, treatment goals and measurable objectives in addition to affiliations with other levels of care to assist in accessing clinically necessary "wraparound" support services. Additionally, this level of care addresses the patient's needs for psychiatric and medical services through consultation or referral arrangements, and case management.

2. Program Requirements

a. Minimum of 3-5 hours of program per day. (Time spent eating a meal is not included in this; however, up to 2, 15-minute breaks per day may be included. Meal planning and preparation may be included if this activity has a clear therapeutic goal, and is part of the client's treatment plan).
b. Minimum of 3-5 days per week of programming (minimum of 9 hours per ek).
c. Minimum of 2 one-hour group therapy sessions per day. Maximum of ten clients per group therapy session. Educational and recreational sessions may have more participants.
d. Minimum of 1 individual therapy session per week, minimum of 50-60 minutes

duration.
e. Family therapy sessions which involve family members, guardians, or significant others in the assessment treatment and continuing care of the client, if family exists and is willing and able to participate.
f. Program allows time for parents to interact with children during course of day if children are in childcare on-site.
g. Educational sessions including the following topics:

i. Substance abuse/dependence/recovery
ii. Information regarding Self-help programs and other outside resources
iii. HIV/STD and Hepatitis infection and risk reduction
iv. Relapse prevention
v. Gender specific issues in addiction and recovery as well as trauma, abuse and
grief issues
vi. Parenting issues (if applicable)

h. The initial treatment plan will be completed within 14 days of admission, reviewed at least weekly and revised as goals are accomplished or new treatment issues arise. If an individual has been referred from a higher level of care, the referring agency’s treatment plan may be utilized on a preliminary basis.

E. Day/PHP Treatment Services

1. Level II.5, Partial Hospitalization/Day Treatment. At least 20 hours of skilled treatment services are provided each week. These services may include individual and group counseling, family therapy, educational groups, occupational and recreational therapy, psychotherapy, or other therapies. These are provided in the amounts, frequency and intensity appropriate to address the objectives of the patient’s treatment plan.

2. Program Specifications.

a. Minimum of 4-5 hours of program per day, and a minimum of 20 hours per week. (Time spent eating a meal is not included in this; however, up to 2, 15-minute breaks per day may be included. Meal planning and preparation may be included if this activity has a clear therapeutic goal, and is part of the client's treatment plan).
b. Minimum of 4-5 days per week of programming (minimum of 20 hours per week).
c. Minimum of 2 one-hour group therapy sessions per day. Maximum of ten clients per group therapy session. Educational and recreational sessions may have more participants.
d. Minimum of 1 individual therapy session per week, minimum of 50-60 minutes duration.
e. Family therapy sessions which involve family members, guardians, or significant others in the assessment treatment and continuing care of the client, if family exists and is willing and able to participate.
f. Program allows time for parents to interact with children during course of day if children are in childcare on-site.
g. Educational sessions including the following topics:

i. Substance abuse/dependence/recovery
ii. Information regarding Self-help programs
iii. HIV/STD and Hepatitis infection and risk reduction
iv. Relapse prevention
v. Gender specific issues in addiction and recovery, as well as trauma, abuse, and grief issues
vi. Parenting issues (if applicable)

h. The initial treatment plan will be completed within 14 days of admission,

Goal #14: Hypodermic Needle Program Footnotes
reviewed at least weekly and revised as goals are accomplished or new treatment issues arise. If an individual has been referred from a higher level of care, the referring agency's treatment plan may be utilized on a preliminary basis.

Rhode Island

Goal #15: Independent Peer Review

GOAL # 15. An agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers that receive funds from the block grant (See 42 U.S.C. 300x-53(a) and 45 C.F.R. 96.136).

FY 2004 (Compliance):

FY 2006 (Progress):

FY 2007 (Intended Use):

GOAL # 15

-- An agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers that receive funds from the block grant (See 42 U.S.C. 300x-53(a) and 45 C.F.R. 96.136).

FFY 2004 (Compliance):

FFY 2006 (Progress):

FFY 2007 (Intended Use):

GOAL # 15: An agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers that receive funds from the block grant.

In FFY2004, the state:

1.) continued the process for Independent Peer Review
2.) held committee meetings as needed
3.) conducted six reviews representing various treatment modalities
4.) included client satisfaction surveys in the process, conducted by RICares (Rhode Island's recovery advocacy group)
5.) received an annual report from the peer review committee summarizing strategies offered by providers and consumers to enhance care
6.) recognized efforts of the committee and sought to recruit new members
7.) facilitated feedback and suggestions of the committee to the training coordinator for the Drug and Alcohol Treatment Association on training needs twice during the year.

In FFY2006, the state:

1.) continued to evaluate and revise the peer review process, including revision of forms
2.) held monthly committee meetings
3.) invited several providers of behavioral health services to present information on their programs to the committee
4.) selected five programs for review by the committee representing various treatment modalities
5.) included client satisfaction surveys in the process, conducted by RICares (Rhode Island's recovery advocacy group)
6.) provided technical assistance to various providers as a result of their requests during site reviews
7.) received an annual report from the peer review committee, summarizing strategies offered by providers and consumers to enhance care

8.) Mailed copies of the annual report to all licensed providers and DATA
9.) posted the annual report on MHRH's website
10.) recognized efforts of the committee during one of the semi-annual meeting with the Executive Director of Behavioral Healthcare to review the annual report with their comments/concerns regarding access to services.
11.) facilitated feedback and suggestions of the committee to the training coordinator for the Drug and Alcohol Treatment Association on training needs on a semi-annual basis
12.) included mental health agencies in peer review process to examine effectiveness of co-occurring disorders treatment.

In FFY2007 the state will:

1.) continue the Independent Peer Review process
2.) continue to hold monthly committee meetings
3.) continue to evaluate and revise the process and committee as needed
4.) continue to receive an annual report from the committee
5.) continue to post the annual report on MHRH's website
6.) continue to meet with the Executive Director of Behavioral Healthcare semi-annually to review the annual report and to be updated on MHRH new programs/funding issues
7.) continue to conduct lottery selection of programs for review and include all funded modalities of treatment
8.) continue to include client satisfaction surveys in the peer review site review process, conducted by RICares (Rhode Island's recovery advocacy group)
9.) recognize efforts of the committee during a luncheon/breakfast, where the lottery selection will be held, as well as presenting the annual report to all licensed providers, their staff, DATA and MHRH staff who attend and mail copies to those not in attendance..
10.) recruit new members through a mass mailing to all licensed chemical dependency professionals, as well as at the luncheon/breakfast mentioned above
11.) continue to provide technical assistance in response to provider requests
12.) continue to facilitate feedback and suggestions to the training coordinator of DATA regarding on a semi-annual basis
13.) continue to invite providers of various behavioral health services to present information on their programs to the committee
14.) include mental health agencies in peer review process to examine effectiveness of co-occurring disorders treatment.

GOAL # 15

-- An agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers that receive funds from the block grant (See 42 U.S.C. 300x-53(a) and 45 C.F.R. 96.136).

FFY 2004 (Compliance):

FFY 2006 (Progress):

FFY 2007 (Intended Use):

GOAL # 15: An agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers that receive funds from the block grant.

In FFY2004, the state:

1.) continued the process for Independent Peer Review
2.) held committee meetings as needed
3.) conducted six reviews representing various treatment modalities
4.) included client satisfaction surveys in the process, conducted by RICares (Rhode Island's recovery advocacy group)
5.) received an annual report from the peer review committee summarizing strategies offered by providers and consumers to enhance care
6.) recognized efforts of the committee and sought to recruit new members
7.) facilitated feedback and suggestions of the committee to the training coordinator for the Drug and Alcohol Treatment Association on training needs twice during the year.

In FFY2006, the state:

1.) continued to evaluate and revise the peer review process, including revision of forms
2.) held monthly committee meetings
3.) invited several providers of behavioral health services to present information on their programs to the committee
4.) selected five programs for review by the committee representing various treatment modalities
5.) included client satisfaction surveys in the process, conducted by RICares (Rhode Island's recovery advocacy group)
6.) provided technical assistance to various providers as a result of their requests during site reviews
7.) received an annual report from the peer review committee, summarizing strategies offered by providers and consumers to enhance care

8.) Mailed copies of the annual report to all licensed providers and DATA
9.) posted the annual report on MHRH's website
10.) recognized efforts of the committee during one of the semi-annual meeting with the Executive Director of Behavioral Healthcare to review the annual report with their comments/concerns regarding access to services.
11.) facilitated feedback and suggestions of the committee to the training coordinator for the Drug and Alcohol Treatment Association on training needs on a semi-annual basis
12.) included mental health agencies in peer review process to examine effectiveness of co-occurring disorders treatment.

In FFY2007 the state will:

1.) continue the Independent Peer Review process
2.) continue to hold monthly committee meetings
3.) continue to evaluate and revise the process and committee as needed
4.) continue to receive an annual report from the committee
5.) continue to post the annual report on MHRH's website
6.) continue to meet with the Executive Director of Behavioral Healthcare semi-annually to review the annual report and to be updated on MHRH new programs/funding issues
7.) continue to conduct lottery selection of programs for review and include all funded modalities of treatment
8.) continue to include client satisfaction surveys in the peer review site review process, conducted by RICares (Rhode Island's recovery advocacy group)
9.) recognize efforts of the committee during a luncheon/breakfast, where the lottery selection will be held, as well as presenting the annual report to all licensed providers, their staff, DATA and MHRH staff who attend and mail copies to those not in attendance..
10.) recruit new members through a mass mailing to all licensed chemical dependency professionals, as well as at the luncheon/breakfast mentioned above
11.) continue to provide technical assistance in response to provider requests
12.) continue to facilitate feedback and suggestions to the training coordinator of DATA regarding on a semi-annual basis
13.) continue to invite providers of various behavioral health services to present information on their programs to the committee
14.) include mental health agencies in peer review process to examine effectiveness of co-occurring disorders treatment.

GOAL # 15

-- An agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers that receive funds from the block grant (See 42 U.S.C. 300x-53(a) and 45 C.F.R. 96.136).

FFY 2004 (Compliance):

FFY 2006 (Progress):

FFY 2007 (Intended Use):

GOAL # 15: An agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers that receive funds from the block grant.

In FFY2004, the state:

1.) continued the process for Independent Peer Review
2.) held committee meetings as needed
3.) conducted six reviews representing various treatment modalities
4.) included client satisfaction surveys in the process, conducted by RICares (Rhode Island's recovery advocacy group)
5.) received an annual report from the peer review committee summarizing strategies offered by providers and consumers to enhance care
6.) recognized efforts of the committee and sought to recruit new members
7.) facilitated feedback and suggestions of the committee to the training coordinator for the Drug and Alcohol Treatment Association on training needs twice during the year.

In FFY2006, the state:

1.) continued to evaluate and revise the peer review process, including revision of forms
2.) held monthly committee meetings
3.) invited several providers of behavioral health services to present information on their programs to the committee
4.) selected five programs for review by the committee representing various treatment modalities
5.) included client satisfaction surveys in the process, conducted by RICares (Rhode Island's recovery advocacy group)
6.) provided technical assistance to various providers as a result of their requests during site reviews
7.) received an annual report from the peer review committee, summarizing strategies offered by providers and consumers to enhance care

8.) Mailed copies of the annual report to all licensed providers and DATA
9.) posted the annual report on MHRH's website
10.) recognized efforts of the committee during one of the semi-annual meeting with the Executive Director of Behavioral Healthcare to review the annual report with their comments/concerns regarding access to services.
11.) facilitated feedback and suggestions of the committee to the training coordinator for the Drug and Alcohol Treatment Association on training needs on a semi-annual basis
12.) included mental health agencies in peer review process to examine effectiveness of co-occurring disorders treatment.

In FFY2007 the state will:

1.) continue the Independent Peer Review process
2.) continue to hold monthly committee meetings
3.) continue to evaluate and revise the process and committee as needed
4.) continue to receive an annual report from the committee
5.) continue to post the annual report on MHRH's website
6.) continue to meet with the Executive Director of Behavioral Healthcare semi-annually to review the annual report and to be updated on MHRH new programs/funding issues
7.) continue to conduct lottery selection of programs for review and include all funded modalities of treatment
8.) continue to include client satisfaction surveys in the peer review site review process, conducted by RICares (Rhode Island's recovery advocacy group)
9.) recognize efforts of the committee during a luncheon/breakfast, where the lottery selection will be held, as well as presenting the annual report to all licensed providers, their staff, DATA and MHRH staff who attend and mail copies to those not in attendance..
10.) recruit new members through a mass mailing to all licensed chemical dependency professionals, as well as at the luncheon/breakfast mentioned above
11.) continue to provide technical assistance in response to provider requests
12.) continue to facilitate feedback and suggestions to the training coordinator of DATA regarding on a semi-annual basis
13.) continue to invite providers of various behavioral health services to present information on their programs to the committee
14.) include mental health agencies in peer review process to examine effectiveness of co-occurring disorders treatment.

Rhode Island

Attachment H: Independent Peer Review

Attachment H: Independent Peer Review (See 45 C.F.R. 96.122(f)(3)(v))
For the fiscal year two years prior (FY 2005) to the fiscal year for which the State is applying for funds:

In up to three pages provide a description of the State's procedures and activities undertaken to comply with the requirement to conduct independent peer review during FY 2005 (See 42 U.S.C. 300x-53(a)(1) and 45 C.F.R. 96.136).

Examples of procedures may include, but not be limited to:

- the role of the single State authority (SSA) for substance abuse prevention activities and treatment services in the development of operational procedures implementing independent peer review;
- the role of the State Medical Director for Substance Abuse Services in the development of such procedures;
- the role of the independent peer reviewers; and
- the role of the entity(ies) reviewed.

Examples of activities may include, but not be limited to:

- the number of entities reviewed during the applicable fiscal year;
- technical assistance made available to the entity(ies) reviewed; and
- technical assistance made available to the reviewers, if applicable.

Attachment H: Independent Peer Review *(See 45 C.F.R. 96.122(f)(3)(v))*

For the fiscal year two years prior (FFY 2005) to the fiscal year for which the State is applying for funds:

*In **up to three pages** provide a description of the State's procedures and activities undertaken to comply with the requirement to conduct independent peer review during FY 2005 (See 42 U.S.C. 300x-53(a) and 45 C.F.R. 96.136.)*

*Examples of **procedures** may include, but not be limited to:*

__ the role of the single State authority (SSA) for substance abuse prevention activities and treatment services in the development of
operational procedures implementing independent peer review;
__ the role of the State Medical Director for Substance Abuse Services in the development of such procedures;
__ the role of the independent peer reviewers; and
__ the role of the entity(ies) reviewed

*Examples of **activities** may include, but not be limited to:*

__ the number of entities reviewed during the applicable fiscal year;
__ technical assistance made available to the entity(ies) reviewed; and
__ technical assistance made available to the reviewers, if applicable.

Attachment H - Independent Peer Review

To address the requirements to establish and sustain a Peer Review Process:

The Division of Behavioral Healthcare, as the SSA in Rhode Island, in response to the Block Grant mandate established in 1993 for the implementation of a Peer Review Process, formally notified and invited clinical supervisors from each of the contract treatment programs to participate in Peer Review.

As a result of this, all who expressed an interest in participating formed a work group and began to design a process by which to assess quality care.

The Peer Review Development Committee was given required elements for Peer Review as listed in the Federal Register to guide them. A standardized evaluation tool and protocol for review was developed by this committee of clinicians.

As other states were in the same development situation, resource information to use in developing the process was generally not available, the RI Peer Review Process has been one that has and continues to evolve.

Since its inception in 1994, programs have been selected and reviewed. Each year an annual report is written. This report articulates concerns, identifies barriers to treatment and treatment effectiveness and summarizes strategies offered by providers, consumers and the committee themselves to enhance care.

The annual report is presented to the Division, where it is reviewed by Division staff. The principal in-house reviewers are staff who have both a clinical background in substance abuse treatment services and a nursing/medical background. The annual report is submitted to the Director of Mental Health, Retardation and Hospitals for departmental approval and implementation.

This approach provides the Division the ability to disseminate and implement the findings systematically.

The overall charge of the Independent Peer Reviewers in Rhode Island is abstracted from the pertinent federal regulations:

- to review the quality and appropriateness of treatment services, with the goal of improving services within the limitations of technology, resources and patient/client circumstances.

Specific responsibilities of the Peer Review Committee include:

- Meet with the training coordinator from the Drug and Alcohol Treatment Association twice yearly to provide input on training needs.
- Recruit new members
- Screen Peer Review applications for eligibility/modality
- Lottery selection for agencies to fulfill mandate
- Selection of Peers that match agency and modality
- Reconvene after all mandated agency site reviews
- Prepare and present annual report to Department of Mental Health, Retardation an Hospitals
- Evaluate, process and make necessary revisions
- Participate in training
- Monthly committee meetings
- Conduct on-site reviews
- Provide Peer support
- Offer technical assistance to treatment providers
- Participate in monthly Peer supervision

Peer Review members receive continuing education units (CEU□s) to be used towards license re-certification.

The process of selecting the programs to be reviewed and their responsibilities are:

Agency is selected by lottery
Agencies are selected from each of the five modalities, with no modality having more than two selected:

- Residential treatment
- Outpatient treatment
- Day treatment
- Methadone maintenance
- Detox

Agencies are notified that their agency has been selected:

- They are provided with names and phone numbers of the Peer Review members (assigned to match modality)
- Agencies have the option to request, for any reason, a different Peer Reviewer from the one originally assigned
- Agencies are asked to assign a representative to coordinate the process
- Date is set for Peer Review

In 2006, the Peer Review Committee lottery was conducted
All providers were mailed a copy of the previous annual report, DATA (Drug and Alcohol Treatment Association) and the legislature by DATA.

For the site visit:

A pre-brief interview is conducted; this time is used for:

- personal introductions
- a re-cap of the letter sent to agency regarding Peer Review protocols
- an explanation of Peer Review components, including necessary elements
- confidentiality relevant to this process
- a tour of the facility

The actual review is comprised of:

- a check of three records active and/or closed
- interviews are conducted with consumers by the coordinator of RICAREs, (a consumer advocacy group) along with Peer Review members regarding barriers to treatment. Consumers also complete a client satisfaction survey.

Subsequently, an exit interview is conducted; this time is used to:

- communicate positive observations/strengths of program;
- give feedback relevant to review of records as they relate to required elements;
- solicit feedback from agency relevant to:
- the Peer Review process
- concerns/issues for annual report;
- discuss previous annual report objectives and status
- interview staff
- discuss among Peer Reviewers and staff the main objective, assess and improve quality and

appropriateness of care
- offer technical assistance to providers

Through a lottery process, the Independent Peer Review Committee selected five programs to review during SFY 2005-2006. The selected programs represented:

- outpatient (1)
- partial hospitalization (1)
- adolescent residential (1)
- adult male residential (1)
- methadone maintenance (1)

No formal outside technical assistance was provided during the period as a direct result of the Independent Review process, nor was any provided to the Peer Review Committee.

Assistance was provided to programs by:

The Peer Review process, which includes pre and post interviews with each program. Through these mechanisms, issues either directly identified through Peer Review or otherwise known, are discussed and appropriate means to address the items are part of the agenda.

Rhode Island

Goal #16: Disclosure of Patient Records

GOAL # 16. An agreement to ensure that the State has in effect a system to protect patient records from inappropriate disclosure (See 42 U.S.C. 300x-53(b), 45 C.F.R. 96.132(e), and 42 C.F.R. part 2).

FY 2004 (Compliance):

FY 2006 (Progress):

FY 2007(Intended Use):

GOAL # 16

An agreement to ensure that the State has in effect a system to protect from inappropriate disclosure of patient records (See 42 U.S.C. 300x-53(b) and 45 C.F.R. 96.132(e)).

FFY 2004 (Compliance):

FFY 2006 (Progress):

FFY 2007 (Intended Use):

In FFY2004, the State:

1) Funded and provided trainings on Confidentiality of Patient records (42 CFR Part 2) to all agencies and departments serving persons with substance abuse issues.
2) Funded the Drug and Alcohol Treatment Association of Rhode Island, (DATA) as the State contracted training entity, and required ongoing trainings regarding disclosure of patient records.
3) Supported the certification process, which mandates trainings on Confidentiality of Patient Records for all certified counselors, and proficiency in this area on oral exams.
4) Specified confidentiality requirements in the State contract with all treatment agencies, and monitored them for compliance.
5) Worked to implement HIPPA provisions throughout our system of care.

In FFY 2006, the State:

1) Continued to fund and provide trainings on Confidentiality of Patient Records to all agencies and collaterals serving persons with substance abuse issues.
2) Continued to fund the Drug and Alcohol Treatment Association of Rhode Island, (DATA), as the State contracted training entity, and continued to require their delivery of ongoing trainings regarding Disclosure of Patient Records.
3) Continued to support the certification process which requires trainings on issues of confidentiality and proficiency in this area on oral exams.
4) Continued to specify confidentiality requirement in our Licensing Regulations and State contracts with all treatment agencies, and continued to monitor them for compliance.
5) Continued to implement and monitor HIPPA provisions throughout our system of care.
6) The Licensing Board for Chemical Dependency Professionals imposed appropriate sanctions following one complaint and investigation of violations of 42CFR Part 2 and HIPPA.

In FFY 2007, the State:

1) Will continue to fund and provide trainings on Confidentiality of Patient Records to all agencies and collaterals serving persons with substance abuse issues.
2) Will continue to fund the Drug and Alcohol Treatment Association of Rhode Island, (DATA) as the State contracted training entity, and will continue to require their delivery of ongoing trainings regarding Disclosure of Patient Records.
3) Will continue to support the Certification process which requires training on issues regarding Confidentiality of Patient Records, and proficiency in this area on oral exams.
4) Will continue to specify confidentiality requirements regarding Disclosure of Patient Records through our Licensing Regulations and State contracts with all treatment agencies, and to monitor them for compliance.
5) Will continue to implement and monitor HIPPA provisions throughout our system of care.
6) The Department of Behavioral Healthcare Services and the Licensing Board for Chemical Dependency Professionals will continue to follow-up on investigations of inappropriate disclosure of patient records and information, and to impose appropriate sanctions.

GOAL # 16

An agreement to ensure that the State has in effect a system to protect from inappropriate disclosure of patient records (See 42 U.S.C. 300x-53(b) and 45 C.F.R. 96.132(e)).

FFY 2004 (Compliance):

FFY 2006 (Progress):

FFY 2007 (Intended Use):

In FFY2004, the State:

1) Funded and provided trainings on Confidentiality of Patient records (42 CFR Part 2) to all agencies and departments serving persons with substance abuse issues.
2) Funded the Drug and Alcohol Treatment Association of Rhode Island, (DATA) as the State contracted training entity, and required ongoing trainings regarding disclosure of patient records.
3) Supported the certification process, which mandates trainings on Confidentiality of Patient Records for all certified counselors, and proficiency in this area on oral exams.
4) Specified confidentiality requirements in the State contract with all treatment agencies, and monitored them for compliance.
5) Worked to implement HIPPA provisions throughout our system of care.

In FFY 2006, the State:

1) Continued to fund and provide trainings on Confidentiality of Patient Records to all agencies and collaterals serving persons with substance abuse issues.
2) Continued to fund the Drug and Alcohol Treatment Association of Rhode Island, (DATA), as the State contracted training entity, and continued to require their delivery of ongoing trainings regarding Disclosure of Patient Records.
3) Continued to support the certification process which requires trainings on issues of confidentiality and proficiency in this area on oral exams.
4) Continued to specify confidentiality requirement in our Licensing Regulations and State contracts with all treatment agencies, and continued to monitor them for compliance.
5) Continued to implement and monitor HIPPA provisions throughout our system of care.
6) The Licensing Board for Chemical Dependency Professionals imposed appropriate sanctions following one complaint and investigation of violations of 42CFR Part 2 and HIPPA.

In FFY 2007, the State:

1) Will continue to fund and provide trainings on Confidentiality of Patient Records to all agencies and collaterals serving persons with substance abuse issues.
2) Will continue to fund the Drug and Alcohol Treatment Association of Rhode Island, (DATA) as the State contracted training entity, and will continue to require their delivery of ongoing trainings regarding Disclosure of Patient Records.
3) Will continue to support the Certification process which requires training on issues regarding Confidentiality of Patient Records, and proficiency in this area on oral exams.
4) Will continue to specify confidentiality requirements regarding Disclosure of Patient Records through our Licensing Regulations and State contracts with all treatment agencies, and to monitor them for compliance.
5) Will continue to implement and monitor HIPPA provisions throughout our system of care.
6) The Department of Behavioral Healthcare Services and the Licensing Board for Chemical Dependency Professionals will continue to follow-up on investigations of inappropriate disclosure of patient records and information, and to impose appropriate sanctions.

GOAL # 16

An agreement to ensure that the State has in effect a system to protect from inappropriate disclosure of patient records (See 42 U.S.C. 300x-53(b) and 45 C.F.R. 96.132(e)).

FFY 2004 (Compliance):

FFY 2006 (Progress):

FFY 2007 (Intended Use):

In FFY2004, the State:

1) Funded and provided trainings on Confidentiality of Patient records (42 CFR Part 2) to all agencies and departments serving persons with substance abuse issues.
2) Funded the Drug and Alcohol Treatment Association of Rhode Island, (DATA) as the State contracted training entity, and required ongoing trainings regarding disclosure of patient records.
3) Supported the certification process, which mandates trainings on Confidentiality of Patient Records for all certified counselors, and proficiency in this area on oral exams.
4) Specified confidentiality requirements in the State contract with all treatment agencies, and monitored them for compliance.
5) Worked to implement HIPPA provisions throughout our system of care.

In FFY 2006, the State:

1) Continued to fund and provide trainings on Confidentiality of Patient Records to all agencies and collaterals serving persons with substance abuse issues.
2) Continued to fund the Drug and Alcohol Treatment Association of Rhode Island, (DATA), as the State contracted training entity, and continued to require their delivery of ongoing trainings regarding Disclosure of Patient Records.
3) Continued to support the certification process which requires trainings on issues of confidentiality and proficiency in this area on oral exams.
4) Continued to specify confidentiality requirement in our Licensing Regulations and State contracts with all treatment agencies, and continued to monitor them for compliance.
5) Continued to implement and monitor HIPPA provisions throughout our system of care.
6) The Licensing Board for Chemical Dependency Professionals imposed appropriate sanctions following one complaint and investigation of violations of 42CFR Part 2 and HIPPA.

In FFY 2007, the State:

1) Will continue to fund and provide trainings on Confidentiality of Patient Records to all agencies and collaterals serving persons with substance abuse issues.
2) Will continue to fund the Drug and Alcohol Treatment Association of Rhode Island, (DATA) as the State contracted training entity, and will continue to require their delivery of ongoing trainings regarding Disclosure of Patient Records.
3) Will continue to support the Certification process which requires training on issues regarding Confidentiality of Patient Records, and proficiency in this area on oral exams.
4) Will continue to specify confidentiality requirements regarding Disclosure of Patient Records through our Licensing Regulations and State contracts with all treatment agencies, and to monitor them for compliance.
5) Will continue to implement and monitor HIPPA provisions throughout our system of care.
6) The Department of Behavioral Healthcare Services and the Licensing Board for Chemical Dependency Professionals will continue to follow-up on investigations of inappropriate disclosure of patient records and information, and to impose appropriate sanctions.

Rhode Island

Goal #17: Charitable Choice

GOAL #17. An agreement to ensure that the State has in effect a system to comply with 42 U.S.C. 300x-65 and 42 C.F.R. part 54 (See 42 C.F.R. 54.8(c)(4) and 54.8(b), Charitable Choice Provisions and Regulations).

FY 2004 (Compliance): Not Applicable

FY 2006 (Progress):

FY 2007 (Intended Use):

Under Charitable Choice, States, local governments, and religious organizations, each as SAMHSA grant recipients, must: (1) ensure that religious organizations that are providers provide notice of their right to alternative services to all potential and actual program beneficiaries (services recipients); (2) ensure that religious organizations that are providers refer program beneficiaries to alternative services; and (3) fund and/or provide alternative services. The term “alternative services” means services determined by the State to be accessible and comparable and provided within a reasonable period of time from another substance abuse provider (“alternative provider”) to which the program beneficiary (“services recipient”) has no religious objection.

The purpose of Attachment I is to document how your State is complying with these provisions.

GOAL #17.--An agreement to ensure that the State has in effect a system to comply with 42 U.S.C. 300x-65 and 42 C.F.R. part 54 (See 42 C.F.R. 54.8(c)(4) and 54.8(b), Charitable Choice Provisions and Regulations.

FY 2004 (Compliance): Not Applicable

FY 2006 (Progress):

FY 2007 (Intended Use):

Under Charitable Choice, States, local governments, and religious organizations, each as SAMHSA grant recipients, must: (1) ensure that religious organizations that are providers provide notice of their right to alternative services to all potential and actual program beneficiaries (services recipients); (2) ensure that religious organizations that are providers refer program beneficiaries to alternative services; and (3) fund and/or provide alternative services. The term "alternative services" means services determined by the State to be accessible and comparable and provided within a reasonable period of time from another substance abuse provider ("alternative provider") to which the program beneficiary ("services recipient") has no religious objection.

In FFY2004, the state:
1.) N/A

In FFY2006, the state:
1.) Did not have contracts with faith-based organizations. The Rhode Island Division of Behavioral Healthcare Services contracts for substance abuse treatment services using a competitive procurement process. Only licensed organizations are eligible to receive funding through the contract process. The state does not currently and has not in the past funded religious organizations to provide substance abuse treatment. The state's regulations and requirements for licensure do not exclude faith-based organizations from applying for licensure or prohibit their bidding on contracts, when available. Technical assistance for faith-based organizations working toward licensure was available throughout FFY 2006.

In FFY2007, the state will:
1.) Continue to work with faith-based organizations on attaining program licensure. In anticipation that faith-based organizations may need technical assistance to become licensed, the state will provide such assistance on request.

GOAL #17.--An agreement to ensure that the State has in effect a system to comply with 42 U.S.C. 300x-65 and 42 C.F.R. part 54 (See 42 C.F.R. 54.8(c)(4) and 54.8(b), Charitable Choice Provisions and Regulations.

FY 2004 (Compliance): Not Applicable

FY 2006 (Progress):

FY 2007 (Intended Use):

Under Charitable Choice, States, local governments, and religious organizations, each as SAMHSA grant recipients, must: (1) ensure that religious organizations that are providers provide notice of their right to alternative services to all potential and actual program beneficiaries (services recipients); (2) ensure that religious organizations that are providers refer program beneficiaries to alternative services; and (3) fund and/or provide alternative services. The term "alternative services" means services determined by the State to be accessible and comparable and provided within a reasonable period of time from another substance abuse provider ("alternative provider") to which the program beneficiary ("services recipient") has no religious objection.

In FFY2004, the state:
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In FFY2006, the state:
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In FFY2007, the state will:
1.) Continue to work with faith-based organizations on attaining program licensure. In anticipation that faith-based organizations may need technical assistance to become licensed, the state will provide such assistance on request.

GOAL #17.--An agreement to ensure that the State has in effect a system to comply with 42 U.S.C. 300x-65 and 42 C.F.R. part 54 (See 42 C.F.R. 54.8(c)(4) and 54.8(b), Charitable Choice Provisions and Regulations.

FY 2004 (Compliance): Not Applicable

FY 2006 (Progress):

FY 2007 (Intended Use):

Under Charitable Choice, States, local governments, and religious organizations, each as SAMHSA grant recipients, must: (1) ensure that religious organizations that are providers provide notice of their right to alternative services to all potential and actual program beneficiaries (services recipients); (2) ensure that religious organizations that are providers refer program beneficiaries to alternative services; and (3) fund and/or provide alternative services. The term "alternative services" means services determined by the State to be accessible and comparable and provided within a reasonable period of time from another substance abuse provider ("alternative provider") to which the program beneficiary ("services recipient") has no religious objection.

In FFY2004, the state:
1.) N/A

In FFY2006, the state:
1.) Did not have contracts with faith-based organizations. The Rhode Island Division of Behavioral Healthcare Services contracts for substance abuse treatment services using a competitive procurement process. Only licensed organizations are eligible to receive funding through the contract process. The state does not currently and has not in the past funded religious organizations to provide substance abuse treatment. The state's regulations and requirements for licensure do not exclude faith-based organizations from applying for licensure or prohibit their bidding on contracts, when available. Technical assistance for faith-based organizations working toward licensure was available throughout FFY 2006.

In FFY2007, the state will:
1.) Continue to work with faith-based organizations on attaining program licensure. In anticipation that faith-based organizations may need technical assistance to become licensed, the state will provide such assistance on request.

State:
Rhode Island

Attachment I

Under Charitable Choice, States, local governments, and religious organizations, each as SAMHSA grant recipients, must: (1) ensure that religious organizations that are providers provide notice of their right to alternative services to all potential and actual program beneficiaries (services recipients); (2) ensure that religious organizations that are providers refer program beneficiaries to alternative services; and (3) fund and/or provide alternative services. The term “alternative services” means services determined by the State to be accessible and comparable and provided within a reasonable period of time from another substance abuse provider (“alternative provider”) to which the program beneficiary (“services recipient”) has no religious objection.

The purpose of Attachment I is to document how your State is complying with these provisions.

Attachment I - Charitable Choice

For the fiscal year prior (FY 2006) to the fiscal year for which the State is applying for funds provide a description of the State’s procedures and activities undertaken to comply with the provisions.

Notice to Program Beneficiaries - Check all that apply:

☒ Use model notice provided in final regulations.

☐ Use notice developed by State (attached copy).

☐ State has disseminated notice to religious organizations that are providers.

☐ State requires these religious organizations to give notice to all potential beneficiaries.

Referrals to Alternative Services - Check all that apply:

☐ State has developed specific referral system for this requirement.

☐ State has incorporated this requirement into existing referral system(s).

☐ SAMHSA’s Treatment Facility Locator is used to help identify providers.

☐ Other networks and information systems are used to help identify providers.

☐ State maintains record of referrals made by religious organizations that are providers.

☒ 0 Enter total number of referrals necessitated by religious objection to other substance abuse providers ('alternative providers'), as define above, made in previous fiscal year. Provide total ONLY; no information on specific referrals required.

Brief description (one paragraph) of any training for local governments and faith-based and community organizations on these requirements.

In FFY2004, the state:
1.) N/A

In FFY2006, the state:
1.) Did not have contracts with faith-based organizations. The Rhode Island Division of Behavioral Healthcare Services contracts for substance abuse treatment services using a competitive procurement process. Only licensed organizations are eligible to receive funding through the contract process. The state does not currently and has not in the past funded religious organizations to provide substance abuse treatment. The state's regulations and requirements for licensure do not exclude faith-based organizations from applying for licensure or prohibit their bidding on contracts, when available. Technical assistance for faith-based organizations working toward licensure was available throughout FFY 2006.

In FFY2007, the state will:
1.) Continue to work with faith-based organizations on attaining program licensure. In anticipation that faith-based organizations may need technical assistance to become licensed, the state will provide such assistance on request.

State:
Rhode Island

Attachment J

If your State plans to apply for any of the following waivers, check the appropriate box and submit the request for a waiver at the earliest possible date.

- ☐ To expend not less than an amount equal to the amount expended by the State for FY 1994 to establish new programs or expand the capacity of existing programs to make available treatment services designed for pregnant women and women with dependent children (See 42 U.S.C. 300x-22(b)(2) and 45 C.F.R. 96.124(d))

- ☐ Rural area early intervention services HIV requirements (See 42 U.S.C. 300x-24(b)(5)(B) and 45 C.F.R. 96.128(d))

- ☐ Improvement of process for appropriate referrals for treatment, continuing education, or coordination of various activities and services (See 42 U.S.C. 300x-28(d) and 45 C.F.R. 96.132(d))

- ☐ Statewide maintenance of effort (MOE) expenditure levels (See 42 U.S.C. 300x-30(c) and 45 C.F.R. 96.134(b))

- ☐ Construction/rehabilitation (See 42 U.S.C. 300x-31(c) and 45 C.F.R. 96.135(d))

If your State proposes to request a waiver at this time for one or more of the above provisions, include the waiver request as an attachment to the application, if possible. The Interim Final Rule, 45 C.F.R. 96.124(d), 96.128(d), 96.132(d), 96.134(b), and 96.135(d), contains information regarding the criteria for each waiver, respectively. A formal waiver request must be submitted to SAMHSA at some point in time if not included as an attachment to the application.

Attachment J Footnotes
N/A

Rhode Island

Attachment J: Waivers

Attachment J: Waivers

If your State proposes to request a waiver at this time for one or more of the above provisions, include the waiver request as an attachment to the application, if possible. The Interim Final Rule, 45 C.F.R. 96.124(d), 96.128(d), 96.132(d), 96.134(b), and 96.135(d), contains information regarding the criteria for each waiver, respectively. A formal waiver request must be submitted to SAMHSA at some point in time if not included as an attachment to the application.

N/A

Rhode Island

Description of Calculations

Description of Calculations

In a brief narrative, provide a description of the amounts and methods used to calculate the following: (a) the base for services to pregnant women and women with dependent children as required by 42 U.S.C. 300x-22(b)(1); and, for 1994 and subsequent fiscal years report the Federal and State expenditures for such services; (b) the base and Maintenance of Effort (MOE) for tuberculosis services as required by 42 U.S.C. 300x-24(d); and, (c) for designated States, the base and MOE for HIV early intervention services as required by 42 U.S.C. 300x-24(d) (See 45 C.F.R. 96.122(f)(5)(ii)(A)(B)(C)).

State of Rhode Island
Women's, Tuberculosis, and HIV Services Expenditure History

A. Women' Services

I. Expenditure History

FY 1994 to FY 2006 act	
FY	Expenditure
1994	1,964,739
1995	2,241,734
1996	2,241,714
1997	2,082,462
1998	2,291,501
1999	2,325,506
2000	2,771,273
2001	2,798,676
2002	2,366,566
2003	2,396,697
2004	2,324,527
2005	2,421,799
2006	2,489,661

II. Narrative Description - Calculation Methods related to SAPT Expenditure Requirements

The base included the non-federal and Block Grant costs of services provided to pregnant women and women with dependent children who were indigent, with income insufficient to pay for the cost of treatment, and the services were not covered by private insurance or Medicaid. The base was established by:

1. identifying the FFY 1992 non-federal and Block Grant payments made to women's only programs serving pregnant and women with children. These included residential and intensive outpatient programs.

2. calculating the value of services provided in all other programs during FFY 1992 which served pregnant women and women with children by extracting utilization data from the Division's Client Information System which collects data on all admissions and discharges from all contract providers.
   The contracts specify various interventions and services that the contract program must either directly provide or arrange when the client is a pregnant woman or a woman with dependent children.
   By contract program, determined the number of women admitted during FFY 1992, calculated a cost/payment for each program based on the number of women served as a percent of the total census served in that program and applied that factor to the program's total non-federal and Block Grant FFY 1992 contract reimbursement.

3. identifying the annual debt service cost, principal and interest payments, for General Obligation debt issued for women's only facilities serving pregnant women and women with dependent children. The annual debt service expense for substance abuse related issued proceeds is all non-federal funds, and is appropriated to this Division .
   The State issues General Obligation debt by specific project. For this Division, the project proceeds are used to acquire, construct or expand treatment facilities. The annual debt service expense was calculated using twenty year debt retirement with an average interest cost of 5.5 percent.

4. Allocated 5.0 percent of the FFY 1993 and FFY 1994 SAPT awards. Each of the grant awards was $5,824,174, with 5.0 percent equal to $291,208.

5. Recap:

   - 1,382,323 = 1992 Base
   - 291,208 = 5% of FFY 93 Award of $5,824,174
   - 291,208 = 5% of FFY 94 Award of $5,824,174
   - 1,964,739

for the succeeding periods, used the same methodology by:

1. identifying the non-federal and Block Grant funds directed to women's only programs serving pregnant and women with children

2. as of FFY 1995, this State's 1115 waiver, RIte Care covers the full range of substance abuse treatment services to include detox, residential, intensive outpatient, methadone and outpatient. The RIte Care program covers the former Aid for Dependent Children (AFDC) caseload which is almost entirely composed of pregnant women and women with dependent children. The estimated annual State (non-federal) match cost for the substance abuse component of the service plan is $302,000 yearly.

Starting in FFY 1996, this amount is included in the women's expenditure basis.

3. continue to identify the annual debt service cost for General Obligation debt issued specifically to acquire, expand or improve women's only facilities serving pregnant women and women with dependent children.
   The annual debt service continues to be calculated using twenty year debt retirement with an average interest cost of 5.5 percent.

All of our program expenditures are initiated by the Division, with disbursement made through the State's central accounting system. Yearly the women's expenditures are reviewed, verified and evaluated for Block Grant compliance by State auditors when conducting the annual single audit of the SAPT Block Grant.

B. Tuberculosis Service

I. Expenditure History

FY 1992 to FY 2006 act	
FY	Expenditure
1991	216,000
1992	236,663
1993	118,332
1994	Data is missing
1995	195,777
1996	225,620
1997	285,912
1998	316,606
1999	339,591
2000	340,000
2001	440,000
2002	450,077
2003	430,012
2004	337,298
2005	346,023
2006	411,959

II. Narrative Description - Calculation Methods related to SAPT Expenditure Requirements

In Rhode Island, the State's Department of Health (DOH) is the State's public health agency, and is responsible for the statewide availability of Tuberculosis (TB) testing and treatment. The Department's program provides universal access for TB treatment.

The base was established using SFY 1991 and 1992 total actual non-federal expenditures for TB services, as reported by the DOH. For all subsequent periods the total actual non-federal expenditures for TB services are reported by DOH to this Division for inclusion in the SAPT application.

As this State's TB program provides for universal access, total expenditures have and continue to be reported in the SAPT.

The TB expenditures are disbursed through the central state accounting system and yearly the expenditures are reviewed, verified and evaluated for Block Grant compliance by State auditors when conducting the annual single audit of the Block Grant.

All contract substance abuse treatment agencies are required to make available tuberculosis ("TB") services directly or through arrangements with other public or nonprofit private entities to all individuals receiving treatment for substance abuse. Specified requirements include counseling; testing to determine whether the individual has been infected with mycobacteria tuberculosis to determine the appropriate form of treatment, and referral of individuals infected by TB for appropriate medical evaluation and treatment. Other than a limited number of treatment programs that conduct onsite testing, all treatment programs use the Department of Health program of TB services.

C. HIV Early Intervention

I. Expenditure History

FY 1992 to FY 2006 act	
FY	Expenditure
1991	Data is missing
1992	100,473
1993	108,298
1994	367,126
1995	394,110
1996	358,640
1997	324,084
1998	387,100
1999	411,960
2000	205,999
2001	140,200
2002	140,200
2003	201,599
2004	265,265
2005	234,287
2006	263,409

II. Narrative Description - Calculation Methods related to SAPT Expenditure Requirements

In Rhode Island, the State's Department of Health (DOH) is the State's public health agency, and is responsible for the statewide availability of HIV early intervention, testing and treatment. The Department's program provides universal access for HIV treatment.

The base was established using SFY 1992 and 1993 total actual non-federal expenditures for HIV services, as reported by the DOH. For all subsequent periods the total actual non-federal expenditures for HIV services are reported by DOH to this Division for inclusion in the SAPT application. Expenditures for the State's HIV prevention and early intervention services are only report in the SAPT.

The HIV early intervention expenditures are disbursed through the central state accounting system and yearly the expenditures are reviewed, verified and evaluated for Block Grant compliance by State auditors when conducting the annual single audit of the Block Grant.

All contract substance abuse treatment agencies are required to make available HIV services directly or through arrangements with other public or nonprofit private entities to all individuals receiving treatment for substance abuse. Specified requirements include counseling; testing to determine whether the individual has been infected and referral of individuals for appropriate medical evaluation and treatment. Other than a limited number of treatment programs that conduct onsite testing, all treatment programs use the Department of Health program of HIV services.

SUBSTANCE ABUSE STATE AGENCY SPENDING REPORT

State:
Rhode Island

Dates of State Expenditure Period:
From 7/1/2005 to 6/30/2006

Activity	A. SAPT Block Grant FY 2004 Award (Spent)	B. Medicaid (Federal, State and Local)	C. Other Federal Funds (e.g., Medicare, other public welfare)	D. State Funds	E. Local Funds (excluding local Medicaid)	F. Other
1. Substance abuse treatment and rehabilitation	$4,847,893	$5,524,430	$115,694	$8,393,409	$	$
2. Primary Prevention	$1,696,898		$3,550,960	$2,339,136	$	$
3. Tuberculosis Services	$	$	$	$	$	$
4. HIV Early Intervention Services	$	$	$	$	$	$
5. Administration (excluding program/provider level)	$127,007		$381,046	$1,848,601	$	$
6. Column Total	$6,671,798	$5,524,430	$4,047,700	$12,581,146	$	$

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Form 4a

Primary Prevention Expenditures Checklist

State:
Rhode Island

	Block Grant FY 2004	Other Federal	State	Local	Other
Information Dissemination	**$106,394**	**$327,700**	**$349,644**	**$**	**$**
Education	**$897,556**	**$484,590**	**$437,533**	**$**	**$**
Alternatives	**$61,800**	**$58,701**	**$139,858**	**$**	**$**
Problem Identification & Referral	**$568,667**	**$1,924,898**	**$791,011**	**$**	**$**
Community-Based Process	**$**	**$160,578**	**$279,715**	**$**	**$**
Environmental	**$**	**$450,715**	**$279,715**	**$**	**$**
Other	**$62,481**	**$143,780**	**$**	**$**	**$**
Section 1926 - Tobacco	**$**	**$**	**$61,660**	**$**	**$**
TOTAL	**$1,696,898**	**$3,550,962**	**$2,339,136**	**$**	**$**

Form 4b

Resource Development Expenditure Checklist

State:
Rhode Island

Did your State fund resource development activities from the FY 2004 block grant?

☒ Yes ☐ No

	Treatment	Prevention	Additional Combined	Total
Planning, Coordination and Needs Assessment	**$**	**$**	**$**	**$**
Quality Assurance	**$**	**$**	**$**	**$**
Training (post-employment)	**$55,901**	**$28,035**	**$**	**$83,936**
Education (pre-employment)	**$**	**$**	**$**	**$**
Program Development	**$**	**$**	**$**	**$**
Research and Evaluation	**$**	**$**	**$**	**$**
Information Systems	**$**	**$**	**$**	**$**
TOTAL	**$55,901**	**$28,035**	**$**	**$83,936**

Expenditures on Resource Development Activities are:

☒ **Actual** ☐ **Estimated**

SUBSTANCE ABUSE ENTITY INVENTORY

State:
Rhode Island

					FISCAL YEAR 2004		
1. Entity Number	2. National Register (I-SATS) ID	3. Area Served	4. State Funds	5. SAPT Block Grand Funds for Substance Abuse Prevention (other than primary prevention) and Treatment Services	5.a. SAPT Block Grant Funds for Services for Pregnant Women and Women with Dependent Children	6. SAPT Block Grant Funds for Primary Prevention	7. SAPT Block Grant Funds for Early Intervention Services for HIV (if applicable)
100007	100007	State Total	$1,398,575	$	$	$	$
100017	100017	State Total	$	$241,866	$	$241,866	$
100020	100020	State Total	$	$62,483	$	$62,483	$
100021	100021	State Total	$525	$137,412	$	$101,797	$
100023	100023	State Total	$	$358	$358	$	$
100139	100139	State Total	$	$41,455	$	$41,455	$
100212	100212	State Total	$286,775	$	$	$	$
100220	100220	State Total	$3,120	$250,281	$250,281	$	$
100238	100238	State Total	$226,860	$530,873	$	$	$
100279	100279	State Total	$745,633	$591,660	$	$591,660	$
100311	100311	State Total	$	$66,285	$	$66,285	$
100329	100329	State Total	$116,346	$	$	$	$

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State:
Rhode Island

					FISCAL YEAR 2004			
1. Entity Number	2. Inventory of Substance Abuse Treatment Services (I-SATS) ID	3. Area Served	4. State Funds		5. SAPT Block Grand Funds for Substance Abuse Prevention (other than primary prevention) and Treatment Services	5.a. SAPT Block Grant Funds for Services for Pregnant Women and Women with Dependent Children	6. SAPT Block Grant Funds for Primary Prevention	7. SAPT Block Grant Funds for Early Intervention Services for HIV (if applicable)
100337	100337	State Total	$663,933		$502,216	$	$	$
100428	100428	State Total	$189,613		$393,151	$	$	$
100444	100444	State Total	$246,037		$	$	$	$
100477	100477	State Total	$		$80,676	$26,933	$	$
100550	100550	State Total	$597,273		$	$	$	$
100568	100568	State Total	$186,073		$	$	$	$
100584	100584	State Total	$		$29,193	$29,193	$	$
100675	100675	State Total	$		$59,558	$	$59,558	$
100741	100741	State Total	$		$97,463	$	$97,463	$
100824	100824	State Total	$		$91,411	$91,411	$	$
100857	100857	State Total	$597,273		$	$	$	$
100881	100881	State Total	$96,340		$	$	$	$

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State:
Rhode Island

					FISCAL YEAR 2004			
1. Entity Number	2. Inventory of Substance Abuse Treatment Services (I-SATS) ID	3. Area Served	4. State Funds		5. SAPT Block Grand Funds for Substance Abuse Prevention (other than primary prevention) and Treatment Services	5.a. SAPT Block Grant Funds for Services for Pregnant Women and Women with Dependent Children	6. SAPT Block Grant Funds for Primary Prevention	7. SAPT Block Grant Funds for Early Intervention Services for HIV (if applicable)
100915	100915	State Total	$3,193,418		$749,580	$	$	$
300028	300028	State Total	$597,273		$	$	$	$
301067	301067	State Total	$176,148		$144,227	$	$	$
301356	301356	State Total	$67,689		$223,397	$	$50,733	$
750024	750024	State Total	$		$44,119	$	$44,119	$
750115	750115	State Total	$172,454		$145,418	$	$	$
750123	750123	State Total	$102,549		$213,801	$	$	$
750156	750156	State Total	$219,904		$	$	$	$
900629	900629	State Total	$410,770		$666,590	$	$	$
900652	900652	State Total	$236,819		$	$	$	$
900678	900678	State Total	$210,502		$193,918	$	$	$
900686	900686	State Total	$466,553		$	$	$	$

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State:
Rhode Island

					FISCAL YEAR 2004			
1. Entity Number	2. Inventory of Substance Abuse Treatment Services (I-SATS) ID	3. Area Served	4. State Funds		5. SAPT Block Grand Funds for Substance Abuse Prevention (other than primary prevention) and Treatment Services	5.a. SAPT Block Grant Funds for Services for Pregnant Women and Women with Dependent Children	6. SAPT Block Grant Funds for Primary Prevention	7. SAPT Block Grant Funds for Early Intervention Services for HIV (if applicable)
900751	900751	State Total	$		$77,733	$	$77,733	$
900769	900769	State Total	$66,593		$84,614	$	$84,614	$
900975	900975	State Total	$138,352		$100,750	$	$	$
900991	900991	State Total	$170,225		$338,020	$	$	$
901049	901049	State Total	$		$92,713	$	$92,713	$
901056	901056	State Total	$163,272		$114,155	$	$	$
901058	901058	State Total	$		$4,846	$	$1,619	$
901059	901059	State Total	$		$82,800	$	$82,800	$
901062	901062	State Total	$101,090		$91,769	$91,769	$	$
TOTAL	TOTAL	TOTAL	$11,847,987		$6,544,791	$489,945	$1,696,898	$

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PROVIDER ADDRESS TABLE

State:
Rhode Island

NO PROVIDER ADDRESSES LISTED

Prevention Strategy Report

State:
Rhode Island

Column A (Risks)	Column B (Strategies)	Column C (Providers)
No Risk Category Assigned [-99]	Clearinghouse/information resources centers [1]	0
	Resources directories [2]	0
	Media campaigns [3]	0
	Brochures [4]	0
	Radio and TV public service announcements [5]	0
	Speaking engagements [6]	0
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	0
	Information lines/Hot lines [8]	0
	Parenting and family management [11]	0
	Ongoing classroom and/or small group sessions [12]	0
	Peer leader/helper programs [13]	0
	Education programs for youth groups [14]	0
	Mentors [15]	0
	Preschool ATOD prevention programs [16]	0
	Youth/adult leadership activities [22]	0
	Community service activities [24]	0
	Recreation activities [26]	0
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	0
	Systematic planning [42]	0
	Multi-agency coordination and collaboration/coalition [43]	0
	Community team-building [44]	0
	Promoting the establishment of review of alcohol, tobacco, and drug use policies in schools [51]	0

Form 6a: Risk - Strategies (...continued)

State:
Rhode Island

Column A (Risks)	Column B (Strategies)	Column C (Providers)
(cont...) No Risk Category Assigned [-99]	Guidance and technical assistance on monitoring enforcement governing availability and distribution of alcohol, tobacco, and other drug use [52]	0
	Other, specify [55]	0
	Responsible Beverage Service Training [71]	0
	Media Advocacy [72]	0
	Restrictions on Alcohol Use at Community Events [73]	0
	Strengthening Laws Related to Underage Alcohol and Tobacco Use [74]	0
Children of Substance Abusers [1]	Parenting and family management [11]	0
	Ongoing classroom and/or small group sessions [12]	0
	Education programs for youth groups [14]	0
	Student Assistance Programs [32]	0
	Driving while under the influence/driving while intoxicated education programs [33]	0
	Other, specify [34]	0
	Other, specify [55]	0
Violent and Delinquent Behavior [4]	Parenting and family management [11]	0
	Ongoing classroom and/or small group sessions [12]	0
	Peer leader/helper programs [13]	0
	Education programs for youth groups [14]	0
	Mentors [15]	0
	Youth/adult leadership activities [22]	0
	Community service activities [24]	0
	Recreation activities [26]	0
	Student Assistance Programs [32]	0

Form 6a: Risk - Strategies (...continued)

State:
Rhode Island

Column A (Risks)	Column B (Strategies)	Column C (Providers)
(cont...) Violent and Delinquent Behavior [4]	Other, specify [34]	0
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	0
	Multi-agency coordination and collaboration/coalition [43]	0
	Community team-building [44]	0
	Accessing services and funding [45]	0
	Other, specify [55]	0
Mental Health Problems [5]	Parenting and family management [11]	0
	Ongoing classroom and/or small group sessions [12]	0
	Peer leader/helper programs [13]	0
	Education programs for youth groups [14]	0
	Mentors [15]	0
	Community service activities [24]	0
	Recreation activities [26]	0
	Student Assistance Programs [32]	0
	Other, specify [34]	0
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	0
	Multi-agency coordination and collaboration/coalition [43]	0
	Community team-building [44]	0
	Accessing services and funding [45]	0
	Other, specify [55]	0
Economically Disadvantaged [6]	Parenting and family management [11]	0
	Ongoing classroom and/or small group sessions [12]	0

Form 6a: Risk - Strategies (...continued)

State:
Rhode Island

Column A (Risks)	Column B (Strategies)	Column C (Providers)
(cont...) Economically Disadvantaged [6]	Peer leader/helper programs [13]	0
	Education programs for youth groups [14]	0
	Mentors [15]	0
	Community service activities [24]	0
	Recreation activities [26]	0
	Other, specify [34]	0
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	0
	Multi-agency coordination and collaboration/coalition [43]	0
	Community team-building [44]	0
	Accessing services and funding [45]	0
	Promoting the establishment of review of alcohol, tobacco, and drug use policies in schools [51]	0
	Other, specify [55]	0
Abuse Victims [8]	Ongoing classroom and/or small group sessions [12]	0
	Student Assistance Programs [32]	0
Already Using Substances [9]	Resources directories [2]	0
	Speaking engagements [6]	0
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	0
	Information lines/Hot lines [8]	0
	Parenting and family management [11]	0
	Ongoing classroom and/or small group sessions [12]	0
	Peer leader/helper programs [13]	0
	Mentors [15]	0

Form 6a: Risk - Strategies (...continued)

State:
Rhode Island

Column A (Risks)	Column B (Strategies)	Column C (Providers)
(cont...) Already Using Substances [9]	Youth/adult leadership activities [22]	0
	Community service activities [24]	0
	Recreation activities [26]	0
	Student Assistance Programs [32]	0
	Driving while under the influence/driving while intoxicated education programs [33]	0
	Other, specify [34]	0
	Other, specify [55]	0
Recent Immigrants [11]	Parenting and family management [11]	0
	Ongoing classroom and/or small group sessions [12]	0
	Peer leader/helper programs [13]	0
	Education programs for youth groups [14]	0
	Recreation activities [26]	0
	Other, specify [55]	0
Dropout Risk/Academic Difficulties [12]	Parenting and family management [11]	0
	Ongoing classroom and/or small group sessions [12]	0
	Peer leader/helper programs [13]	0
	Education programs for youth groups [14]	0
	Mentors [15]	0
	Youth/adult leadership activities [22]	0
	Community service activities [24]	0
	Recreation activities [26]	0
	Student Assistance Programs [32]	0

Form 6a: Risk - Strategies (...continued)

State:
Rhode Island

Column A (Risks)	Column B (Strategies)	Column C (Providers)
(cont...) Dropout Risk/Academic Difficulties [12]	Other, specify [34]	0
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	0
	Multi-agency coordination and collaboration/coalition [43]	0
	Community team-building [44]	0
	Accessing services and funding [45]	0
	Other, specify [55]	0

TREATMENT UTILIZATION MATRIX

State:
Rhode Island

Dates of State Expenditure Period:
From 7/1/2005 to 6/30/2006 (Same as Form 1)

			Costs Per Person		
Level of Care	**A. Number of Admissions**	**B. Number of Persons Served**	**C. Mean Cost of Services**	**D. Median Cost of Services**	**E. Standard Deviation of Cost**
Detoxification (24 hour Care)					
1. Hospital Inpatient			**$.00**	**$.00**	**$.00**
2. Free-standing Residential	**1,724**	**1,736**	**$2,204.00**	**$2,204.00**	**$2,204.00**
Rehabilitation / Residential					
3. Hospital Inpatient	**310**	**345**	**$891.00**	**$891.00**	**$891.00**
4. Short-term (up to 30 days)	**130**	**137**	**$5,813.00**	**$5,813.00**	**$5,813.00**
5. Long-term (over to 30 days)	**693**	**884**	**$5,813.00**	**$5,813.00**	**$5,813.00**
Ambulatory (Outpatient)					
6. Outpatient	**510**	**3,369**	**$891.00**	**$891.00**	**$891.00**
7. Intensive Outpatient	**356**	**430**	**$891.00**	**$891.00**	**$891.00**
8. Detoxification			**$.00**	**$.00**	**$.00**
Methadone	**632**	**2,261**	**$643.00**	**$643.00**	**$643.00**

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Form 7a Footnotes
Category 3 (Hospital Inpatient) is captured as partial hospital/Day treatment

Form 7b

Number Of Persons Served (Unduplicated Count) For Alcohol And Other Drug Use In State-Funded Services By Age, Sex, And Race/Ethnicity

State:
Rhode Island

AGE GROUP	A. TOTAL	B. White		C. Black		D. Native Hawaiian / Other Pacific Islander		E. Asian		F. American Indian / Alaska Native		G. More than one race reported		H. Unknown		I. Not Hispanic or Latino		J. Hispanic or Latino	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
1. 17 and under	323	147	96	39	20	1		6		3				11		207	116	65	14
2. 18-24	1,119	539	366	101	54	3	1	4	3	7	5			18	18	672	447	113	57
3. 25-44	5,055	2,566	1,678	379	241	8	1	5	2	48	27			58	42	3,064	1,991	442	184
4. 45-64	1,652	951	423	140	77	3		1		18	6			29	4	1,142	510	82	31
5. 65 and over	21	14	3	2										2		18	3	4	
6. Total	8,170	4,217	2,566	661	392	15	2	16	5	76	38			118	64	5,103	3,067	706	286
7. Pregnant Women	120		95		18		1				2				4		120		20

Did the State base the values reported on Form 7A and 7B from a client-based system(s) with unique client identifiers?

☒ **Yes** ☐ **No**

Numbers of Persons Served who were admitted in a period prior to the 12 month reporting period: 9,162

Form 7b Footnotes

The number of pregnant women listed on Form 7b does not reflect the number of pregnant women receiving substance abuse treatment services. The number indicated does not include pregnant women covered by RIte Care (the State's managed medicaid program). Pregnant women and women with dependent children with incomes up to 150% FPL are eligible for RIte Care and do not pay a monthly premium; pregnant women and women with dependent children with incomes between 150 - 250% FPL are also eligible for RIte Care, but do have to pay a monthly premium, which ranges from a low of $61 to a high of $92 per month. RIte Care coverage includes drug and alcohol treatment. RIte Care participants can enroll in one of three programs/plans. An associated program, RIte Share, is a premium assistance program that helps qualifying families get health insurance coverage through their employer (or spouse's employer). Most low-income pregnant women requiring substance abuse treatment are covered by RIte Care or RIte Share.

State:
Rhode Island

SSA (MOE Table I)

Total Single State Agency (SSA) Expenditures for Substance Abuse (Table I)

PERIOD (A)	EXPENDITURES (B)	B1(2004) + B2(2005) / 2 (C)
SFY 2004 (1)	$15,798,054	
SFY 2005 (2)	$15,924,833	$15,861,444
SFY 2006 (3)	$16,398,203	

Are the expenditure amounts reported in Columns B "actual" expenditures for the State fiscal years involved?

FY 2004 ☒ **Yes** ☐ **No**

FY 2005 ☒ **Yes** ☐ **No**

FY 2006 ☒ **Yes** ☐ **No**

If estimated expenditures are provided, please indicate when "actual" expenditure data will be submitted to SAMHSA(mm/dd/yyyy):

The MOE for State fiscal year(SFY) 2006 is met if the amount in Box B3 is greater than or equal to the amount in Box C2 assuming the State complied with MOE requirements in these previous years.

The State may request an exclusion of certain non-recurring expenditures for a singular purpose from the calculation of the MOE, provided it meets CSAT approval based on review of the following information:

Did the State have any non-recurring expenditures for a specific purpose which were not included in the MOE calculation?

☐ **Yes** ☒ **No** **If yes, specify the amount** **$0**

Did the State include these funds in previous year MOE calculations? ☐ **Yes** ☒ **No**

When did the State submit a request to the SAMHSA Administration to exclude these funds from the MOE calculations(Date)?

TB (MOE Table II)

State:
Rhode Island

Statewide Non-Federal Expenditures for Tuberculosis Services to Substance Abusers in Treatment (Table II)

(BASE TABLE)

PERIOD	Total of All State Funds Spent on TB Services (A)	% of TB Expenditures Spent on Clients who were Substance Abusers in Treatment (B)	Total State Funds Spent on Clients who were Substance Abusers in Treatment (A x B) (C)	Average of Columns C1 and C2 C1 + C2 / 2 MOE BASE (D)
SFY 1991 (1)	$216,000	100%	$216,000	
SFY 1992 (2)	$236,663	100%	$236,663	$226,332

(MAINTENANCE TABLE)

PERIOD	Total of All State Funds Spent on TB Services (A)	% of TB Expenditures Spent on Clients who were Substance Abusers in Treatment (B)	Total State Funds Spent on Clients who were Substance Abusers in Treatment (A x B)
SFY 2006 (3)	$411,959	100%	$411,959

HIV (MOE Table III)

State:
Rhode Island

Statewide Non-Federal Expenditures for HIV Early Intervention Services to Substance Abusers in Treatment (Table III)

(BASE TABLE)

PERIOD	Total of All State Funds Spent on Early Intervention Services for HIV* (A)	Average of Columns A1 and A2 A1 + A2 / 2 MOE BASE (B)
SFY1992 (1)	$100,473	
SFY1993 (2)	$108,298	$104,386

(MAINTENANCE TABLE)

PERIOD	Total of All State Funds Spent on Early Intervention Services for HIV* (A)
SFY 2006 (3)	$263,409

*** Provided to substance abusers at the site at which they receive substance abuse treatment**

Womens (MOE TABLE IV)

State:
Rhode Island

Expenditures for Services to Pregnant Women and Women with Dependent Children (Table IV)

(MAINTENANCE TABLE)

PERIOD	Total Women's BASE (A)	Total Expenditures (B)
1994	$1,964,739	
2004		$2,324,527
2005		$2,421,799
2006		$2,489,661

Enter the amount the State plans to expend in FY 2007 for services for pregnant women and women with dependent children (amount entered must be not less than amount entered in Table IV Maintenance - Box A {1994}): $2,496,329

State:
Rhode Island

FY 2004 SAPT BLOCK GRANT

Your annual SAPT Block Grant Award for FY 2004 is reflected on Line 8 of the Notice of Block Grant Award

$6,671,798

Rhode Island

1. Planning

1. Planning

This item addresses compliance of the State's planning procedures with several statutory requirements. It requires completion of narratives and a checklist.

These are the statutory requirements:

- 42 U.S.C. 300x-29 requires the State to submit a Statewide assessment of need for both treatment and prevention.
- 42 U.S.C. 300x-51 requires the State to make the State plan public in such a manner as to facilitate public comment from any person during the development of the plan.

In a narrative of up to three pages, describe how your State carries out sub-State area planning and determines which areas have the highest incidence, prevalence, and greatest need. Include a definition of your State's sub-State planning areas. Identify what data is collected, how it is collected, and how it is used in making these decisions. If there is a State, regional, or local advisory council, describe their composition and their role in the planning process. Describe the monitoring process the State will use to assure that funded programs serve communities with the highest prevalence and need. If there is a State Epidemiological Workgroup or a State Epidemiological Outcomes Workgroup, describe its composition and its role in needs assessment, planning, and evaluation processes.

In a narrative of up to two pages, describe the process your State used to facilitate public comment in developing the State's plan and its FY 2007 application for SAPT Block Grant funds.

1. Planning

This item addresses compliance of the State's planning procedures with several statutory requirements. It requires completion of narratives and a checklist.

These are the statutory requirements:

-- Section 1929 requires the State to submit a statewide assessment of need for both treatment and prevention.

-- Section 1941 requires the State to make the State plan public in such a manner as to facilitate public comment from any person during the development of the plan.

In a narrative, describe how your State carries out sub-state area planning and determines which areas have the highest incidence, prevalence and greatest need. Include a definition of your State's sub-state planning areas. Identify what data is collected, how it is collected, and how it is used in making these decisions. States are required to utilize data from CSAT or CSAP needs assessment contracts. If the State does not use this data explain why. If there are any State, regional, or local advisory councils, describe their composition and their role in the planning process. Describe the monitoring process the State will use to assure that funded programs serve communities with the highest prevalence and need.

In a narrative, describe the process your State used to facilitate public comment in developing the State's plan and its FFY 2003 application for SAPT Block Grant funds.

SECTION III: PLANNING

Rhode Island's sub-state planning areas are Providence and non-Providence.

Rhode Island has completed Phases I and II of our federal Center for Substance Abuse Treatment (CSAT) project entitled, ***State Demand and Needs Assessment Studies: Alcohol and Other Drugs.*** *The project was completed by the North Charles Research and Planning Group (NCRPG) (affiliated with Harvard), headed by Dr. William McAuliffe.*

Studies include:

- Telephone Household Study

- Five non-overlapping face-to-face interview surveys with high-risk populations that would be missed by a telephone survey:

- Homeless Study
- Recently Incarcerated Prisoners (DOC)
- Adolescents in Training School [DCYF])
- Group Home Study (adolescents)
- Treatment Client Study (adults and adolescents receiving long-term residential substance abuse treatment; also, incorporated

interviews with outpatient treatment clients to assess their unmet needs)

- Stakeholder Survey - interviewed key informants who were knowledgeable about the state's alcohol and drug treatment system or the treatment needs of these special samples and populations.

- Final Summary Report

The final written reports (deliverables) include:

- *The Substance Abuse Treatment Needs of RI's Neediest Citizens* (Summary Report)
- *Rhode Island Stakeholder Study*
- *The Substance Abuse Treatment Needs of RI's Adolescent Group Home Residents*
- *The Substance Abuse Treatment Needs of Rhode Island's Homeless*
- *The Substance Abuse Treatment Needs of RI's Prisoner and Training School Populations*
- *Treatment Client Study*
- *Household Study*

Phase Two products include:

Study #1: Establishing a Permanent Social Indicator Data System in Rhode Island. The goal of this study is to create a permanent Rhode Island social indicator system that includes data collection, evaluation and analysis activities. This study seeks not only to conduct an essential study for the current family of needs assessment studies, but also to build a key element of Rhode Island's infrastructure for future needs assessments and other uses.

Study #2: Comprehensive Study of Adult and Adolescent Women's Substance Abuse Treatment and Ancillary Service Needs. This study provides information that will enable the State to continue enhancing its substance abuse treatment system. The goal of the study is to provide information on treatment need, demand, and access for adult and adolescent women, primarily for substance abuse services, but also for ancillary services, whose availability may impact the demand and utilization of substance abuse services. This study has been designed to use data from the Family of Studies conducted in Phase 1, supplemented with treatment admissions and social indicator data. Need, unmet demand and obstacles to treatment services have been assessed, and an evaluation of the current service mix and clinical programs were conducted.

Study #3: Hard-Core Abuser Study. This study is designed to give Rhode Island an improved estimate of the treatment needs of hard-core substance abusers, including recently incarcerated populations (adults and youth) and the homeless. The results of this hard-core abuser study will be an

important part of the needs assessment data that will be used in creating a comprehensive treatment plan for the State. Treatment services for hard-core substance abusers are most often the ones that are in short supply, in part because the services are expensive and in part because hard-core abusers are a hidden population.

Study #4: Comprehensive State Treatment Services Plan: This study utilized needs assessment and resource data collected by the State to create a comprehensive treatment services plan for Rhode Island. When designing statewide, comprehensive needs assessment plans for treatment of substance abuse, the State needs to answer three basic planning questions:

a. **How many people are in need of treatment in the State?** The planning goal is to have an adequate supply of services to meet the absolute level of demand that these cases would produce.

b. **Where are they located?** The planning goal is to locate the services where they are needed most.

c. **What mix of treatment modalities do these clients need and want?** The goal is to have the optimal mix of treatment services to achieve maximal effectiveness and efficiency.

DBH continues to utilize the results of the needs assessment in its own grant seeking activities, and routinely shares data with community based agencies seeking prevalence data and preparing funding requests which require justification of need. Information will continue to be shared with other state agencies who mutually serve individuals affected by substance abuse (e.g., Corrections, Health, DCYF, Judicial and Human Services, as well as the "Governor's Council on Behavioral Health", whose membership is comprised of all State Departments, provider agencies (both mental health and substance abuse), legislators, judicial representatives and consumers. It is expected that the results of these studies will be utilized for a wide variety of planning activities, including future Block Grant expenditures, budget hearings, legislative hearings, media requests, academia and requests from community-based agencies and individuals.

As in past years, service allocation planning will take into account a number of assessment mechanisms, including use of needs assessment results, continuation of historical funding, block grant set-aside requirements and emerging trends.

Allocation of future federal and state funding will be determined based on STNAP results, other ad hoc reviews, newly emerging issues, examining client utilization data, and utilizing other existing resources wherever possible to maximize available dollars.

Public Process

The Division annually presents the Block Grant to the Governor's Council on Behavioral Health for public comment. The Governor's Council is, by statute, comprised of representatives of substance abuse treatment and prevention professionals, mental health treatment professionals, consumers of both substance abuse and mental health services, family members of children or elderly consumers of substance abuse and mental health services, members of the judiciary, criminal justice officials, the state mental health advocate, the executive directors of both the Drug and Alcohol Treatment Association and the Council of Community Mental Health Organizations as well as related state department directors or designees, including the Department of Children, Youth and Families, Corrections, Education, Human Services, Elderly Affairs and the Department of MHRH, as well as four members of the legislature representing each of the major political parties, two of which represent the House and 2 representing the Senate. The Council also has a number of members representing racial or ethnic minorities. The composition of the council is extremely diverse, representing all related aspects of substance abuse and mental health, government, providers, consumers and the public at large. The SAPT Block Grant will be posted on the MHRH External Website by the end of January 2007.

PREVENTION STATE PLANNING

Rhode Island's sub-state planning areas are Providence and the rest of the State. The planning process for substance abuse prevention includes the following elements:

1. Needs Assessment:

The Department reviews and analyzes data from several key sources as the primary component of its sub-state planning process. These data sources include: the now annual Youth Tobacco Survey (to which the Department has added several AOD-related survey items), and Youth Risk Behavior Survey; the Department's annual Client Data System Report, Kids Count Rhode Island Report, and the School Assessment of Learning and Teaching (S.A.L.T.) Survey administered in every school district (elementary through high school) statewide. The Department also utilizes social indicator data available through other sources such as: municipal police department and State Police crime reports; statistics provided by the Rhode Island Justice Commission and local Juvenile Hearing Boards; data collected by local substance abuse prevention task forces as part of their required community needs assessment; and information provided by the following State Departments/Agencies: Health, Education, Corrections, Children Youth and Families (DCYF), Social Services and Elderly Affairs.

The Department also utilizes state and sub-state data from the National Survey on Drug Use and Health (NSDUH), which divides the state into four sub-state regions—Bristol and Newport Counties, Providence County, Kent County, and Washington County; and data available through the State Epidemiologic Data Set (SEDS).

Additional data is available from the semi-annual Alcohol Purchase Surveys and the annual Synar Survey.

In addition, informal key informant surveys are conducted at the program, municipal and state level to assist in assessing the level of need for prevention, intervention and treatment services.

The 35 task forces (community coalitions) funded through the Rhode Island Substance Abuse Prevention Act (RISAPA) are required to conduct a community needs assessment every three years. The results of these assessments are incorporated into each coalition's annual program plan.

The Statewide Substance Abuse Prevention Plan developed by the Statewide Prevention Planning Committee of the RI State Incentive Grant was accepted by the state's Children's Cabinet in September 2004. The plan contains a recommendation to create a statewide youth surveillance system that would provide data necessary to support planning by various State agencies, municipal entities, and community-based organizations (CBO's) serving children and youth. The State Epidemiological Workgroup (SEOW) created under Strategic Planning Framework State Incentive Grant (SPF SIG) to oversee the development of the youth surveillance system will inventory current surveillance assets, including survey and social indicator data-sets relevant to ATOD incidence/prevalence and associated risk and protective factors.

The SEOW will develop state-level and municipal-level "community profiles" based on available substance use indicator data, which subsequently will be used to determine which communities are eligible for SPF SIG funding based on documented need for specific services. These state-level and community-level profiles ultimately will be used by the Department to support statewide prevention planning and will be made available to the local task forces for development of municipal-level prevention service plans, community education and the preparation of grant applications. Other Department-funded prevention and treatment agencies will have access to the profiles to support their service plans and grant application development.

The Department uses a management information system for prevention called the Performance Based Prevention System (PBPS) developed by KIT Solutions. This system meets the data management needs of both the Department and prevention providers and supports the planning process at both the statewide and sub-state level.

The core modules for the PBPS are: needs assessment, planning, service activity, process and outcome evaluation, and coalition module. The system includes some of CSAP's identified core measures and will be expanded to include all of the CSAP core measures. Rhode Island has added measures associated with the model program replications funded through the SAPT Block Grant, State Incentive Grant and Safe and Drug Free Schools and Communities. These efforts are intended to facilitate use of established measures, which will improve the quality of both the Department's and the providers' planning and quality control efforts.

The objectives required in the planning module are based on achieving intermediate and outcome objectives rather than implementing activities. Providers are required to provide documentation of incidence, prevalence, and risk factor levels, which informed their selection of outcome and intermediate objectives. The Department regularly provides training on the use of PBPS to all funded prevention providers.

Reflecting Rhode Island's commitment to implement community-based interventions, the Department is collaborating to customize the PBPS's coalition module. When this module is completed, Rhode Island will have the capacity to track the prevention efforts of our community substance abuse prevention coalitions who serve as the primary substance abuse prevention planning organizations within their respective communities.

The Department asked KIT Solutions to revise the Evaluation Module in the Performance-Based Prevention System (PBPS). The Evaluation Module now has the capacity to document actual outcome data and compare it to the originally proposed planning objectives.

Another change made to the PBPS was to have the user designate the funding source associated with the data to be entered at the time of login. This change was made to assist providers who are entering data for multiple funding sources keep track of their data. This change will also allow for annual reports to be generated completely by funding source.

In FFY 2006, training classes were offered based on the level of experience of the provider (new vs. intermediate). The Department provided training for 10 participants on February 8, 2005, 8 participants on February 10, 2005 and for 8 participants on October 6, 2005. PBPS training classes will be offered again during FFY 2007. Lastly, PBPS now contains a function that allows users to provide direct feedback via email without exiting the system. The user can select the Department's Program Manager to whom they would like to direct the message.

Rhode Island has expanded the needs assessment module in PBPS to include local needs assessment data. Local providers have on-line access to incidence and prevalence data, other social indicator data, census data, etc. disaggregated to the municipal level to encourage comprehensive community-wide needs assessments. Additionally, the Department provides training annually to the local prevention task forces on utilizing local data to develop their annual service plans.

A representative from the Department attended the annual KIT User Group meeting that was co-located with the Prevention Research Conference in New York City on August 27, 2005. At the meeting, KIT described a new module that they were developing that would track environmental strategies and capacity building activities and the Department decided to incorporate the module. To date, this module is not yet available from KIT therefore the Department recently began working with KIT to

develop a custom coalition module that will include a logic model/program plan, a capacity plan, an evaluation plan, and a report mechanism that is linked to the logic model. We expect a demo of the new module in September of 2006.

The Department continuously monitors the provision of its funded prevention, intervention, and treatment services through on-site monitoring, and electronic transfer of client data. Monthly data submission is required of all prevention providers. Through the PBPS, the Department is able to run data reports on service utilization. In addition, PBPS generates annual reports at the provider and State level. Prevention providers use these reports to assess the degree to which they met their identified outcome and intermediate objectives for their targeted populations. If data indicate that participant/activity targets projected are not being met, the Department contacts providers to determine what factors may be impacting the program. In some cases targets may be inflated and need to be revised, and in others a plan for outreach or other strategies may be developed. Some changes that we are working on in FY 07 to assist the Department with monitoring service data is to have KIT add a time-line to the Program Module. This will help program managers know the exact months when service activities should be completed and the corresponding data provided. The Department has also revised the categories in the Administrative Time Module and provided category descriptions to make this section more user friendly to the providers with terminology that is more familiar to them in the State.

Prevention organizations funded through the primary prevention set-aside of the Substance Abuse Prevention and Treatment Block Grant to provide community-based prevention services are selected through a competitive procurement process. Applicants are required to detail local needs as determined by a needs assessment, which can include data from the National Survey of Drug Use and Health (NSDUH), RI Kids Count, the Statewide Epidemiological and Outcomes Workgroup (SEOW) associated with the SPF SIG, and other local sources. (Both the NSDUH and the SEOW have identified underage drinking and youthful use of marijuana as areas of concern; this information will be taken into consideration when the RFP for the next SAPT procurement is released for implementation in FFY 09.) All SAPT-funded programs have an annual on-site compliance visit, are required to conduct program evaluation, and enter program data on an ongoing basis into the Performance Based Prevention System, the state's prevention MIS.

SAPT dollars also provide approximately 45 percent of the funding for the state's Student Assistance Program initiative, which provides early identification and intervention services in middle- and high schools. Program expansion is closed, but SAPT and General Fund dollars support SAP in the "core" cities of Providence, Pawtucket, and Warwick. The program is available to all school districts in the state and limited only by the availability of state General Fund dollars. Like other SAPT-funded programs, SAP providers have an annual on-site compliance visit; SAP providers also submit quarterly and annual reports.

2. Involvement of other state, sub-state, and community stakeholders

The Department collaborates with other organizations and individuals to integrate all ATOD prevention services and to ensure that those services are consistent with the results of a statewide needs assessment, local needs assessment and current research findings. Examples of this collaboration include the Department's participation on an interdepartmental work group focused on collection of adolescent health data.

Also, the Department convenes monthly meetings of the RISAPA-funded coalitions. Department staff are also members of the Youth Development Advisory Group.

3. Advisory Councils

- Rhode Island, through its Governor, received a State Incentive Grant (SIG 1) from the Center for Substance Abuse Prevention in late 2001. Rhode Island has in place a Children's Cabinet, which is comprised of all of the Directors of State agencies or Departments providing services to children. In turn, the Children's Cabinet formed the Statewide Prevention Planning Committee (SPPC) that had the primary role of overseeing implementation of the SIG1.

  The SPPC was comprised of mid-level managers from the departments/agencies represented on the Children's Cabinet and an equivalent number of representatives from diverse constituencies including community coalitions, prevention providers, and advocacy groups representing racial and ethnic minorities, healthcare organizations and the private sector. The SPPC was assigned three major tasks: 1) development of a comprehensive state prevention plan, 2) conducting an analysis of current prevention funding streams across all state agencies/departments that provide prevention services to children and youth, and 3) development of the RFP for the 85% of the total SIG 1 allocation required to be allocated directly to the community (sub-recipient funding).

  During the fall of 2003, a needs assessment was conducted which subsequently formed the basis of the competitive sub-recipient RFP. The needs assessment for the SIG 1 included review of municipal data regarding ATOD prevalence rates among youth 12-17 throughout Rhode Island's 39 cities and towns. This data was obtained through the RI Department of Education's Student Assessment of Learning and Teaching Survey (SALT Survey). In addition, the members of the SPPC served as "ambassadors" to their respective interest communities and several service gaps were identified during the course of meetings during 2002-03. The workgroup charged with development of the RFP looked at prevalence rates, as well as the service gaps identified by the SPPC, and US census data for each city and town.

  With respect to the development of the Statewide Prevention Plan the SPPC met biweekly through January of 2003 and then monthly to complete the written version of the statewide prevention plan. The SPPC unanimously approved a set of fifteen recommendations in June 2003. A final draft of the Statewide

Substance Abuse Prevention was presented to and adopted by the Children's Cabinet at their quarterly meeting on September 8, 2004.

The funding stream analysis was conducted by a consultant utilizing a framework unanimously approved by the SIG 1 Interdepartmental Management Team. The preliminary results of the funding stream analysis also were presented at the September 2004 meeting of the Children's Cabinet.

In November of 2003, the SPPC was merged with another sub-committee and the joint committee was re-named as the "Youth Development Advisory Committee" (YDAC).

- Rhode Island has also been awarded a SPF SIG. A component of this Grant was the creation of a State Epidemiological Workgroup (SEOW). The SEOW is responsible for overseeing implementation of the majority of the recommendations contained in the Statewide Prevention Plan, including the development of the statewide youth surveillance system to support state, municipal and program level planning, evaluation and resource allocation.

- Governor's Council on Behavioral Health advises the Governor and General Assembly on policies, goals, and operations of the behavioral healthcare system, including the program areas of substance abuse and mental health and the spectrum of interventions from prevention through treatment to aftercare and recovery supports, and on other matters the Director of Mental Health, Retardation and Hospitals refers to it. The Council also encourages public understanding and support of the behavioral health system. The Council was created in statute and its members appointed by the Governor. It also serves as the required mental health state advisory council and the optional substance abuse prevention and treatment state advisory council.

4. Use of Science-Based Principles

The Department is committed to creating a prevention system consisting of (1) culturally-appropriate evidence-based programs policies and practices, which (2) are organized into comprehensive community-based prevention on the municipal level, and (3) are supported by coordinated funding and technical assistance from the state level.

For example, the Department contracted with the Community Research and Services Team, of the University of Rhode Island to enhance prevention capacity within the Rhode Island substance abuse prevention system. The long-term goal is to improve statewide outcomes via effective planning, use and evaluation of science-based prevention. Capacity building activities have been conducted in three interrelated dimensions: professional development of Department staff, organizational

change/capacity building at the local provider level, and prevention system refinement. The evaluation report is posted at the Department's website.

The Department utilizes a competitive RFP process as the basis for funding of Block Grant, State Incentive Grant, and Safe and Drug Free Schools and Communities programs. RFP's require applicants to use a "logic model" to: a) demonstrate knowledge of the principles of effective prevention programming and familiarity with CSAP's effective/model programs; b) link in a logical manner proposed program activities with identified intermediate objectives [i.e., specific changes in risk and protective factors]; c) specify the final outcomes expected in the target population; and d) evaluate program activities to determine their effectives. The results of these evaluations will be utilized to inform future State and local planning efforts. In developing both the Block Grant and Safe and Drug Free Schools and Communities RFP's, a decision was made to align the RFP requirements with those of the SIG in order to further the development of a coordinated statewide science-based system. Future procurements will employ the Strategic Prevention Framework as an organizing principle.

Rhode Island also has demonstrated commitment to use science-based principles in its decision to contract with the CRST at URI to oversee the local evaluation of the SDFSC grants, SAPT Block Grant-funded Community-based Substance Abuse Prevention grants, and the SIG comprehensive community-wide grants, as well as acting as the statewide evaluation team.

5. Use of Institute of Medicine's prevention classification:

The Department uses the Institute of Medicine's prevention classifications.

6. Coverage of the Six CSAP prevention strategies:

The Department funds activities within each of the six prevention strategy categories under the guiding principle of promoting comprehensive, multi-component prevention interventions. See Goal 2 Prevention for specifics.

7. Program Evaluation Approach and Strategies:

The Department has worked with the Community Research and Services Team (CRST), University of Rhode Island to enhance prevention capacity within the Rhode Island substance abuse prevention system. The long-term goal is to improve statewide outcomes via effective planning, use, and evaluation of science-based prevention.

The Department has contracted with CRST, University of Rhode Island to conduct the evaluation of the "Science-Based Demonstration Projects" funded through the

SAPT Block Grant (ended 6/30/05) and to provide evaluation oversight and technical assistance to evaluators of programs funded with SAPT Block Grants funds (beginning 9/1/05) and USDOE, Safe and Drug Free Schools and Community funds. The final evaluation report of the recently ended SAPT Block Grant-funded projects is available at http://www.mhrh.ri.gov/substance_abuse.htm. and is attached in Appendix A.

Long-term outcomes required under the new Block Grant-funded programs are consistent with national outcome measures (NOMS).

The SIG is being evaluated at three levels; programmatic, community and state. The CRST is serving as the statewide evaluation team and is coordinating the local evaluators for the comprehensive initiatives. CRST also is providing technical assistance as needed to the evaluators for locally developed programs or selected/indicated programs also funded under the SIG. Also, RISAPA-funded coalitions develop annual evaluation plans that identify outcomes, indicators, data sources, and data collection frequency.

The Department requires all contracted prevention providers to conduct both process and outcome evaluation activities: a process evaluation, which documents and describes the implementation and operation of the selected programs, and an outcome evaluation to document and determine the effectiveness of the interventions vis-à-vis the goals and objectives of the project. The SAPT Block Grant, SDFSC and SIG providers allocate a predetermined percentage of grant funds to support program evaluation.

State:
Rhode Island

Criteria for Allocating Funds

Use the following checklist to indicate the criteria your State will use in deciding how to allocate FY 2007 Block Grant funds. Mark all criteria that apply. Indicate the priority of the criteria by placing numbers in the boxes. For example, if the most important criterion is 'incidence and prevalence levels', put a '1' in the box beside that option. If two or more criteria are equal, assign them the same number.

_ Population levels, Specify formula:

2 Incidence and prevalence levels

3 Problem levels as estimated by alcohol/drug-related crime statistics

3 Problem levels as estimated by alcohol/drug-related health statistics

_ Problem levels as estimated by social indicator data

4 Problem levels as estimated by expert opinion

1 Resource levels as determined by (specific method)
ExeLeg Appropriations

_ Size of gaps between resources (as measured by)

and needs (as estimated by)

_ Other (specify):

Planning Checklist Footnotes
Annually SAPT funds are appropriated as part of the State's Annual Operating Budget. The Executive initiated Legislatively enacted budget identifies the overall estimated level of SAPT funds to be spent during a particular fiscal year, along with the non-federal funds for substance abuse prevention and treatment services, plus the other direct costs supporting program operations.

Ultimately, the level of SAPT funds is predicted on the federal award. Actual allocations by service and region are determined by other criteria, as indicated in this checklist, Critera for Allocating Funds.

Treatment Needs Assessment Summary Matrix

State:	Calendar Year:
Rhode Island	2005

1.	2.	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
Substate Planning Area	**Total Population**	**A. Needing treatment services**	**B. That would seek treatment**	**A. Needing treatment services**	**B. That would seek treatment**	**A. Needing treatment services**	**B. That would seek treatment**	**A. Number of DWI arrests**	**B. Number of drug-related arrests**	**C. Other:**	**A. Hepatitis B / 100,000**	**B. AIDS / 100,000**	**C. Tuberculosis / 100,000**
Providence	**173,618**	**0**	**0**	**0**	**0**	**0**	**0**	**37**	**932**	**0**	**0**	**14**	**6**

Substate Planning Area	Total Population	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other:	A. Hepatitis B / 100,000	B. AIDS / 100,000	C. Tuberculosis / 100,000
non-Provid	**874,701**	**0**	**0**	**0**	**0**	**0**	**0**	**2,388**	**2,966**	**0**	**0**	**4**	**3**

Substate Planning Area	Total Population	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other:	A. Hepatitis B / 100,000	B. AIDS / 100,000	C. Tuberculosis / 100,000
State Total	**1,048,319**	**56,709**	**8,178**	**0**	**0**	**10,000**	**1,409**	**2,425**	**3,898**	**0**	**5**	**10**	**5**

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Form 8 Footnotes
Crime statistics were obtained from the "Crime in Rhode Island, 2005". It can be found online at www.risp.ri.gov This is the RI State Police Website.

Census Data was completed in 2002 and will remain the same until 2010.

Incidence of Communicable Disease statistics were obtained from the Department of Health and from the DOH website www.health.ri.gov

Please note that Hep B can only be reported on a statewide level due to the duplication of data.

Treatment Needs by Age, Sex, and Race/Ethnicity

State:	Substate Planning Area [95]:
Rhode Island	State Total

AGE GROUP	A. TOTAL	B. WHITE		C. BLACK OR AFRICAN AMERICAN		D. NATIVE HAWAIIAN / OTHER PACIFIC ISLANDER		E. ASIAN		F. AMERICAN INDIAN / ALASKA NATIVE		G. MORE THAN ONE RACE REPORTED		H. UNKNOWN		I. NOT HISPANIC OR LATINO		J. HISPANIC OR LATINO	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
1. 17 and under	326	149	97	39	20	1	0	6	0	3	0	0	0	11	0	201	117	66	14
2. 18 - 24	1,139	549	373	103	55	3	1	4	3	7	5	0	0	18	18	684	455	115	58
3. 25 - 44	5,185	2,617	1,711	386	245	8	1	5	2	82	27	0	0	59	42	3,157	2,028	450	187
4. 45 - 64	1,682	970	431	142	78	3	0	1	0	18	6	0	0	29	4	1,163	519	83	31
5. 65 and over	21	14	3	2	0	0	0	0	0	0	0	0	0	2	0	18	3	4	0
6. Total	8,353	4,299	2,615	672	398	15	2	16	5	110	38			119	64	5,223	3,122	718	290

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Form 9 Footnotes
Based on past treatment trends and needs, we project an average 2% increase treatment services.

State:
Rhode Island

INTENDED USE PLAN

(Include ONLY Funds to be spent by the agency administering the block grant. Estimated data are acceptable on this form)

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SOURCE OF FUNDS

(24 Month Projection)

Activity (see instructions for using Row 1)	A. FY 2007 SAPT Block Grant	B. Medicaid (Federal, State and Local)	C. Other Federal Funds (e.g., Medicare, other public welfare)	D. State Funds	E. Local Funds (excluding local Medicaid)	F. Other
1. Substance abuse treatment and rehabilitation	$4,534,332	$11,010,076	$383,528	$17,421,750	$0	$0
2. Primary Prevention	$1,594,690		$4,174,066	$5,031,666	$0	$0
3. Tuberculosis Services	$0	$0	$0	$0	$0	$0
4. HIV Early Intervention Services	$131,807	$0	$0	$0	$0	$0
5. Administration (excluding program/provider level)	$329,517		$1,062,350	$3,920,078	$0	$0
6. Column Total	$6,590,346	$11,010,076	$5,619,944	$26,373,494	$	$

Form 11a

Primary Prevention Planned Expenditures Checklist

State:
Rhode Island

	Block Grant FY 2007	Other Federal	State	Local	Other
Information Dissemination	**$99,985**	**$385,203**	**$760,338**	**$**	**$**
Education	**$843,494**	**$569,623**	**$951,463**	**$**	**$**
Alternatives	**$58,077**	**$69,001**	**$304,135**	**$**	**$**
Problem Identification & Referral	**$534,414**	**$2,262,669**	**$1,720,139**	**$**	**$**
Community-Based Process	**$**	**$188,755**	**$608,271**	**$**	**$**
Environmental	**$**	**$529,804**	**$608,271**	**$**	**$**
Other	**$58,720**	**$169,011**	**$**	**$**	**$**
Section 1926 - Tobacco	**$**	**$**	**$79,049**	**$**	**$**
TOTAL	**$1,594,690**	**$4,174,066**	**$5,031,666**	**$**	**$**

Form 11b

Planned Expenditures on Resource Development Activities

State:
Rhode Island

Does your State plan to fund resource development activities with FY 2007 funds?

☒ Yes ☐ No

	Treatment	Prevention	Additional Combined	Total
Planning, Coordination and Needs Assessment	**$**	**$**	**$**	**$**
Quality Assurance	**$**	**$**	**$**	**$**
Training (post-employment)	**$62,561**	**$31,375**	**$**	**$93,936**
Education (pre-employment)	**$**	**$**	**$**	**$**
Program Development	**$**	**$**	**$**	**$**
Research and Evaluation	**$**	**$**	**$**	**$**
Information Systems	**$**	**$**	**$**	**$**
TOTAL	**$62,561**	**$31,375**	**$**	**$93,936**

Form 12

State:
Rhode Island

TREATMENT CAPACITY MATRIX

This form contains data covering a 24 month projection for the period during which your principal agency of the State is permitted to spend the FY 2007 block grand award.

Level of Care	A. Number of Admissions	B. Number of Persons Served
Detoxification (24 hour Care)		
1. Hospital Inpatient		
2. Free-standing Residential	**1,758**	**1,736**
Rehabilitation / Residential		
3. Hospital Inpatient	**316**	**351**
4. Short-term (up to 30 days)	**132**	**139**
5. Long-term (over to 30 days)	**706**	**901**
Ambulatory (Outpatient)		
6. Outpatient	**2,560**	**3,436**
7. Intensive Outpatient	**363**	**438**
8. Detoxification		
Methadone	**650**	**2,328**

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Form 12 Footnotes
Numbers for Categories 1-8 represent a 2% projection and methadone is projects a 3% increase.

State:
Rhode Island

Purchasing Services

Methods for Purchasing This item requires completing two checklists

There are many methods the State can use to purchase substance abuse services. Use the following checklist to describe how your State will purchase services with the FY 2007 block grant award. Indicate the proportion of funding that is expended through the applicable procurement mechanism.

☒	Competitive grants	Percent of Expense: 42.8%
☒	Competitive contracts	Percent of Expense: 49.5%
☒	Non-competitive grants	Percent of Expense: 7.7%
☐	Non-competitive contracts	Percent of Expense: %
☐	Statutory or regulatory allocation to governmental agencies serving as umbrella agencies that purchase or directly operate services	Percent of Expense: %
☐	Other	Percent of Expense: %

(The total for the above categories should equal 100 percent.)

☐	According to county or regional priorities	Percent of Expense: %

Methods for Determining Prices

There are also alternative ways a State can decide how much it will pay for services. Use the following checklist to describe how your State pays for services. Complete any that apply. In addressing a States allocation of resources through various payment methods, a State may choose to report either the proportion of expenditures or proportion of clients served through these payment methods. Estimated proportions are acceptable.

☒	Line item program budget	Percent of Clients Served: % Percent of Expenditures: 54.5%
☒	Price per slot	Percent of Clients Served: % Percent of Expenditures: 45.5%

Rate: 4865 Type of slot: Outpatient Treatment

Rate: 3164 Type of slot: Ambulatory Opiate Treatment

Rate: 22470 Type of slot: Theraputic Residential

☐	Price per unit of service	Percent of Clients Served: % Percent of Expenditures: %

Unit: Rate:

Unit: Rate:

Unit: Rate:

☐ Per capita allocation (Formula):

Percent of Clients Served: %
Percent of Expenditures: %

☐ Price per episode of care:

Percent of Clients Served: %
Percent of Expenditures: %

Rate: Diagnostic Group:

Rate: Diagnostic Group:

Rate: Diagnostic Group:

State:
Rhode Island

Program Performance Monitoring

☒ On-site inspections

(Frequency for treatment:) Bi-Annual & as needed

(Frequency for prevention:) Annual & as needed

☒ Activity Reports

(Frequency for treatment:) Quarterly General Outpatient,

(Frequency for prevention:) Monthly (PBPS)

☒ Management information System

☒ Patient/participant data reporting system

(Frequency for treatment:) Daily, Weekly & Monthly

(Frequency for prevention:) Monthly (PBPS)

☒ Performance Contracts

☒ Cost reports

☒ Independent Peer Review

☒ Licensure standards - programs and facilities

(Frequency for treatment:) Bi-Annual

(Frequency for prevention:) None

☒ Licensure standards - personnel

(Frequency for treatment:) Bi-Annual

(Frequency for prevention:) None

☐ Other (Specify):

Rhode Island

How your State determined the estimates for Form 8 and Form 9

How your State determined the estimates for Form 8 and Form 9

Under 42 U.S.C. 300x-29 and 45 C.F.R. 96.133, States are required to submit annually a needs assessment. This requirement is not contingent on the receipt of Federal needs assessment resources. States are required to use the best available data. Using up to three pages, explain what methods your State used to estimate the numbers of people in need of substance abuse treatment services, the biases of the data, and how the State intends to improve the reliability and validity of the data. Also indicate the sources and dates or timeframes for the data used in making these estimates reported in both Forms 8 and 9. In addition, provide any necessary explanation of the way your State records data or interprets the indices in columns 6 and 7.

How your State determined the estimates for Form 8(Matrix) and Form 9

Under 42 U.S.C. 300x-29 and 45 C.F.R. 96.133, States are required to submit annually a needs assessment. This requirement is not contingent on the receipt of Federal needs assessment resources. States are required to use the best available data. Using up to three pages, explain what methods your State used to estimate the numbers of people in need of substance abuse treatment services, the biases of the data, and how the State intends to improve the reliability and validity of the data. Also indicate the sources and dates or timeframes for the data used in making these estimates reported in both Forms 8 and 9. In addition, provide any necessary explanation of the way your State records data or interprets the indices in columns 6 and 7.

Footnotes for Form 8 (Treatment Needs Assessment Summary Matrix):

Section 2. Total Population: Source: 2002 Census Data, next census will be conducted in 2010.

Section 3. Total Population in Need: Source: State Treatment Needs Assessment Project, "*Study of Rhode Island's Substance Abuse Treatment Service Needs", 2002*

B. "Number that would seek treatment": Includes:

56,709 (Needing Treatment Services Total Population)

2577 (Have not received treatment, would seek if available)
5601 (Have received treatment, but wanted additional)

8178 Total

Section 4. IVDUs in Need: ***Information not available***

Section 5. Number of Women in Need: Source: State Treatment Needs Assessment Project, *"Women's Substance Abuse Treatment Service Needs in Rhode Island", 2002*

B. "Number that would seek treatment": Includes:
416 (Have not received treatment, but would seek, if available)
993 (Have received treatment, but wanted additional)

1409 Total

C. "Number that would seek treatment": Includes:
10,000 (Women needing treatment services)

Section 6. Prevalence of Substance-related Criminal Activity: Source: 2005 Uniform Crime Reports, RI State Police www.risp.ri.gov

- Includes both adult and youth offenders

Section 7. Incidence of Communicable Diseases: Source: RI Department of Health, Office of Communicable Diseases

A. Hepatitis B: Source: RI Department of Health, Office of Communicable Disease, *"Reported cases of Hepatitis B by state, 2005" www.health.ri.gov/disease.*

B. AIDS: Source: RI Department of Health, Office of Communicable Disease, *"Reported cases of AIDS by state, RI, 2005" www.health.ri.gov/disease.*

C. **Tuberculosis:** Source: Department of Health, Office of Communicable Disease, *"Reported cases of Tuberculosis by state, RI, 2005" www.health.ri.gov/disease.*

Footnotes Form 9 (Treatment Needs) Age, Sex, Race/Ethnicity

The data in Form 9 is generated from Rhode Island's CIS system. Based on past treatment trends and needs, we project an average 2% increase treatment services.

State:
Rhode Island

Reporting Period:
From 7/1/2005 To 6/30/2006

FORM T1 - TREATMENT PERFORMANCE MEASURE
EMPLOYMENT STATUS (From Admission to Discharge)

Employment Status - Clients employed (full-time or part-time) (prior 30 days) at admission vs. discharge	Admission Clients (T1)	Discharge Clients (T2)	Absolute/Relative Change
Number of clients employed (full-time and part-time) [numerator]	3,715	4,189	
Total number of clients with non-missing values on employment status [denominator]	12,301	12,240	
Percent of clients employed (full-time and part-time)	30.20%	34.22%	4.02% / 13.32%

THE SECTION BELOW SHOULD BE COMPLETED AT THE TIME DATA IS ENTERED IN THE TABLE ABOVE

T1.1
What is the source of data for this table? (Select all that apply)

- ☒ Client Self Report
- ☐ Administrative Data Source
- ☐ Other: Specify

T1.2
How is Admission/Discharge Basis defined? (Select one)

- ☐ Admission is on the first date of service, prior to which no service has been received for 30 days AND discharge is on the last date of service, subsequent to which no service has been received for 30 days.
- ☒ Admission is on the first date of service in a Program/Service Delivery Unit AND Discharge is on the last date of service in a Program/Service Delivery Unit
- ☐ Other: Specify

T1.3
How was the discharge data collected? (Select all that apply)

- ☐ Not Applicable, data reported on form is collected at time period other than discharge --> Specify:
  - ☐ In-Treatment data days post admission OR ☐ Follow-up data months Post ☐ admission OR ☐ discharge
  - ☐ Other: Specify
- ☒ Discharge data is collected for the census of all (or almost all) clients who were admitted to treatment
- ☐ Discharge data is collected for a sample of all clients who were admitted to treatment
- ☒ Discharge records are directly collected (or in the case of early dropouts) are created for all (or almost all) clients who were admitted to treatment
- ☐ Discharge records are NOT completed for some clients who were admitted to treatment
  Specify proportion of admitted clients with a discharge record: %

T1.4
Was the admission and discharge data linked? (Select all that apply)

- ☒ Yes, all clients at admission were linked with discharge data using a Unique Client ID (UCID). Select type of UCID:
  - ☐ Master Client Index or Master Patient Index, centrally assigned
  - ☐ Social Security Number
  - ☒ Unique client ID based on fixed client characteristics (such as DOB, gender, partial SSN, etc.)
  - ☐ Some other Statewide unique ID
  - ☐ Provider-entity-specific unique ID
- ☐ No, State Management Information System does not utilize a UCID that allows comparison of admission and discharge data on a client specific basis (data developed on a cohort basis) or State relied on other data sources for post admission data
- ☐ No, admission and discharge records were matched using probabilistic record matching

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T1.5
Why are you Unable to Report?
(Select all that apply)

- ☒ Not Applicable, data reported above
- ☐ Information is not collected at Admission
- ☐ Information is not collected at Discharge
- ☐ Information not collected by categories requested
- ☐ State collects information on the indicator area but utilizes a different measure
- ☐ Other: Specify

OMB No. 0930-0080 Approved: 8/26/2004 Expires: 08/31/2007

State Description of Employment Status Data Collection (Form T1)

GOAL

To improve the employment status of persons treated in the States substance abuse treatment system.

MEASURE

The change in all clients receiving treatment who reported being employed (including part-time) at discharge.

STATE CONFORMANCE TO INTERIM STANDARD

States should detail exactly how this information is collected. Where data and methods vary from interim standard, variance should be described.

State collects admission data.

YES ☒ NO ☐

State collects discharge data.

YES ☒ NO ☐

State collects admission and discharge data on employment that can be reported using TEDS definitions.

YES ☒ NO ☐

State reported data using data other than admission and discharge data.

YES ☐ NO ☒

State reported data using administrative data.

YES ☐ NO ☒

DATA SOURCE(S)	Source(s):	Rhode Island uses the "client information system" which collects TEDS information from our treatment providers

DATA ISSUES

Issues:

OMB No. 0930-0080 Approved: 8/26/2004 Expires: 08/31/2007

DATA PLANS IF DATA IS NOT AVAILABLE	State should provide time-framed plans for capturing employment status data on all clients, if data is not currently available. Plans should also discuss barriers, resource needs and estimates of cost.

OMB No. 0930-0080 Approved: 8/26/2004 Expires: 08/31/2007

State:
Rhode Island

Reporting Period:
From 7/1/2005 To 6/30/2006

FORM T2 - TREATMENT PERFORMANCE MEASURE
HOMELESSNESS: Living Status (From Admission to Discharge)

Homelessness - Clients homeless (prior 30 days) at admission vs. discharge	Admission Clients (T1)	Discharge Clients (T2)	Absolute/Relative Change
Number of clients homeless [numerator]	1,491	1,244	
Total number of clients with non-missing values on living arrangements [denominator]	12,301	12,223	
Percent of clients homeless	12.12%	10.18%	-1.94% / -16.03%

THE SECTION BELOW SHOULD BE COMPLETED AT THE TIME DATA IS ENTERED IN THE TABLE ABOVE

T2.1
What is the source of data for this table? (Select all that apply)

- ☒ Client Self Report
- ☐ Administrative Data Source
- ☐ Other: Specify

T2.2
How is Admission/Discharge Basis defined? (Select one)

- ☐ Admission is on the first date of service, prior to which no service has been received for 30 days AND Discharge is on the last date of service, subsequent to which no service has been received for 30 days.
- ☒ Admission is on the first date of service in a Program/Service Delivery Unit AND Discharge is on the last date of service in a Program/Service Delivery Unit
- ☐ Other: Specify

T2.3
How was the discharge data collected? (Select all that apply)

- ☐ Not Applicable, data reported on form is collected at time period other than discharge --> Specify:
  - ☐ In-Treatment data days post admission OR ☐ Follow-up data months Post ☐ admission OR ☐ discharge
  - ☐ Other: Specify
- ☒ Discharge data is collected for the census of all (or almost all) clients who were admitted to treatment
- ☐ Discharge data is collected for a sample of all clients who were admitted to treatment
- ☒ Discharge records are directly collected (or in the case of early dropouts) are created for all (or almost all) clients who were admitted to treatment
- ☐ Discharge records are NOT completed for some clients who were admitted to treatment
  Specify proportion of admitted clients with a discharge record: %

T2.4
Was the admission and discharge data linked? (Select all that apply)

- ☒ Yes, all clients at admission were linked with discharge data using a Unique Client ID (UCID).
  Select type of UCID:
  - ☐ Master Client Index or Master Patient Index, centrally assigned
  - ☐ Social Security Number
  - ☒ Unique client ID based on fixed client characteristics (such as DOB, gender, partial SSN, etc.)
  - ☐ Some other Statewide unique ID
  - ☐ Provider-entity-specific unique ID
- ☐ No, State Management Information System does not utilize a UCID that allows comparison of admission and discharge data on a client specific basis (data developed on a cohort basis) or State relied on other data sources for post admission data
- ☐ No, admission and discharge records were matched using probabilistic record matching

OMB No. 0930-0080 Approved: 8/26/2004 Expires: 08/31/2007

T2.5
Why are you Unable to Report?
(Select all that apply)

- ☒ Not Applicable, data reported above
- ☐ Information is not collected at Admission
- ☐ Information is not collected at Discharge
- ☐ Information not collected by categories requested
- ☐ State collects information on the indicator area but utilizes a different measure
- ☐ Other: Specify

State Description of Homelessness (Living Status) Data Collection (Form T2)*

GOAL

To improve the living conditions of persons treated in the States substance abuse treatment system.

MEASURE

The change in all clients receiving treatment who reported being homeless at discharge.

STATE CONFORMANCE TO INTERIM STANDARD

States should detail exactly how this information is collected. Where data and methods vary from interim standard, variance should be described.

State collects admission data.

YES ☒ NO ☐

State collects discharge data.

YES ☒ NO ☐

State collects admission and discharge data on living status that can be reported using TEDS definitions.

YES ☒ NO ☐

State reported data using data other than admission and discharge data.

YES ☐ NO ☒

State reported data using administrative data.

YES ☐ NO ☒

OMB No. 0930-0080 Approved: 8/26/2004 Expires: 08/31/2007

DATA SOURCE(S)	Source(s):	Rhode Island uses the "client information system" which collects TEDS information from our treatment providers.

DATA ISSUES

Issues:

OMB No. 0930-0080 Approved: 8/26/2004 Expires: 08/31/2007

DATA PLANS IF DATA IS NOT AVAILABLE	State should provide time-framed plans for capturing employment status data on all clients, if data is not currently available. Plans should also discuss barriers, resource needs and estimates of cost.

OMB No. 0930-0080 Approved: 8/26/2004 Expires: 08/31/2007

State:
Rhode Island

Reporting Period:
From 7/1/2005 To 6/30/2006

FORM T3 - TREATMENT PERFORMANCE MEASURE
CRIMINAL JUSTICE INVOLVEMENT (From Admission to Discharge)

Arrests - Clients arrested (any charge) (in prior 30 days) at admission vs. discharge - T3	Admission Clients (T1)	Discharge Clients (T2)	Absolute/Relative Change
Number of Clients arrested [numerator]	2,970	761	
Total number of clients with non-missing values on arrests [denominator]	12,369	12,239	
Percent of clients arrested	24.01%	6.22%	-17.79% / -74.10%

THE SECTION BELOW SHOULD BE COMPLETED AT THE TIME DATA IS ENTERED IN THE TABLE ABOVE

T3.1
What is the source of data for this table? (Select all that apply)

- ☒ Client Self Report
- ☐ Administrative Data Source
- ☐ Other: Specify

T3.2
How is Admission/Discharge Basis defined? (Select one)

- ☐ Admission is on the first date of service, prior to which no service has been received for 30 days AND Discharge is on the last date of service, subsequent to which no service has been received for 30 days.
- ☒ Admission is on the first date of service in a Program/Service Delivery Unit AND Discharge is on the last date of service in a Program/Service Delivery Unit
- ☐ Other: Specify

T3.3
How was the discharge data collected? (Select all that apply)

- ☐ Not Applicable, data reported on form is collected at time period other than discharge --> Specify:
  - ☐ In-Treatment data days post admission OR ☐ Follow-up data months Post ☐ admission OR ☐ discharge
  - ☐ Other: Specify
- ☒ Discharge data is collected for the census of all (or almost all) clients who were admitted to treatment
- ☐ Discharge data is collected for a sample of all clients who were admitted to treatment
- ☒ Discharge records are directly collected (or in the case of early dropouts) are created for all (or almost all) clients who were admitted to treatment
- ☐ Discharge records are NOT completed for some clients who were admitted to treatment
  Specify proportion of admitted clients with a discharge record: %

T3.4
Was the admission and discharge data linked? (Select all that apply)

- ☒ Yes, all clients at admission were linked with discharge data using a Unique Client ID (UCID).
  Select type of UCID:
  - ☐ Master Client Index or Master Patient Index, centrally assigned
  - ☐ Social Security Number
  - ☒ Unique client ID based on fixed client characteristics (such as DOB, gender, partial SSN, etc.)
  - ☐ Some other Statewide unique ID
  - ☐ Provider-entity-specific unique ID
- ☐ No, State Management Information System does not utilize a UCID that allows comparison of admission and discharge data on a client specific basis (data developed on a cohort basis) or State relied on other data sources for post admission data
- ☐ No, admission and discharge records were matched using probabilistic record matching

OMB No. 0930-0080 Approved: 8/26/2004 Expires: 08/31/2007

T3.5
Why are you Unable to Report?
(Select all that apply)

- ☒ Not Applicable, data reported above
- ☐ Information is not collected at Admission
- ☐ Information is not collected at Discharge
- ☐ Information not collected by categories requested
- ☐ State collects information on the indicator area but utilizes a different measure
- ☐ Other: Specify

State Description of Number of Arrests Data Collection (Form T3)

GOAL

To reduce the criminal justice involvement of persons treated in the States substance abuse treatment system.

MEASURE

The change in persons arrested in the last 30 days at discharge for all clients receiving treatment.

STATE CONFORMANCE TO INTERIM STANDARD

States should detail exactly how this information is collected. Where data and methods vary from interim standard, variance should be described.

State collects admission data.

YES ☒ NO ☐

State collects discharge data.

YES ☒ NO ☐

State collects admission and discharge data on criminal justice involvement that can be reported as a Yes/No response.

YES ☒ NO ☐

State reported data using data other than admission and discharge data.

YES ☐ NO ☒

State reported data using administrative data.

YES ☐ NO ☒

DATA SOURCE(S)	Source(s):	Rhode Island uses the "client information system" which collects TEDS information from our treatment providers.

DATA ISSUES	Issues:	Questions are 1) Arrested in 6 months prior to admission, and 2) Arrested between admission and discharge.

OMB No. 0930-0080 Approved: 8/26/2004 Expires: 08/31/2007

DATA PLANS IF DATA IS NOT AVAILABLE	State should provide time-framed plans for capturing employment status data on all clients, if data is not currently available. Plans should also discuss barriers, resource needs and estimates of cost.

OMB No. 0930-0080 Approved: 8/26/2004 Expires: 08/31/2007

State:
Rhode Island

Reporting Period:
From 7/1/2005 To 6/30/2006

FORM T4 - PERFORMANCE MEASURE
CHANGE IN ABSTINENCE - ALCOHOL USE (From Admission to Discharge)

Alcohol Abstinence - Clients with no alcohol use (all clients regardless of primary problem) (use Alcohol Use in last 30 days field) at admission vs. discharge.	Admission Clients (T1)	Discharge Clients (T2)	Absolute/Relative Change
Number of clients abstinent from alcohol [numerator]	5,932	11,123	
Total number of clients with non-missing values on 'used any alcohol' variable [denominator]	12,301	12,240	
Percent of clients abstinent from alcohol	48.22%	90.87%	42.65% / 88.44%

OMB No. 0930-0080 Approved: 8/26/2004 Expires: 08/31/2007

THE SECTION BELOW SHOULD BE COMPLETED AT THE TIME DATA IS ENTERED IN THE TABLE ABOVE

T4.1
What is the source of data for this table? (Select all that apply)

- ☐ Client Self Report confirmed by another source.--> If checked, select one confirmation source.
- ☒ Client Self Report
- ☐ Administrative Data Source
- ☐ Other: Specify
- ☐ Urinalysis, blood test or other biological assay
- ☐ Collateral source
- ☐ Other: Specify

T4.2
How is Admission/Discharge Basis defined? (Select one)

- ☐ Admission is on the first date of service, prior to which no service has been received for 30 days AND Discharge is on the last date of service, subsequent to which no service has been received for 30 days.
- ☒ Admission is on the first date of service in a Program/Service Delivery Unit AND Discharge is on the last date of service in a Program/Service Delivery Unit
- ☐ Other: Specify

T4.3
How was the discharge data collected? (Select all that apply)

- ☐ Not Applicable, data reported on form is collected at time period other than discharge --> Specify:
  - ☐ In-Treatment data days post admission OR ☐ Follow-up data months Post ☐ admission OR ☐ discharge
  - ☐ Other: Specify
- ☒ Discharge data is collected for the census of all (or almost all) clients who were admitted to treatment
- ☐ Discharge data is collected for a sample of all clients who were admitted to treatment
- ☒ Discharge records are directly collected (or in the case of early dropouts) are created for all (or almost all) clients who were admitted to treatment
- ☐ Discharge records are NOT completed for some clients who were admitted to treatment
  Specify proportion of admitted clients with a discharge record: %

T4.4
Was the admission and discharge data linked? (Select all that apply)

- ☒ Yes, all clients at admission were linked with discharge data using a Unique Client ID (UCID).
  Select type of UCID:
  - ☐ Master Client Index or Master Patient Index, centrally assigned
  - ☐ Social Security Number
  - ☒ Unique client ID based on fixed client characteristics (such as DOB, gender, partial SSN, etc.)
  - ☐ Some other Statewide unique ID
  - ☐ Provider-entity-specific unique ID
- ☐ No, State Management Information System does not utilize a UCID that allows comparison of admission and discharge data on a client specific basis (data developed on a cohort basis) or State relied on other data sources for post admission data
- ☐ No, admission and discharge records were matched using probabilistic record matching

OMB No. 0930-0080 Approved: 8/26/2004 Expires: 08/31/2007

T4.5
Why are you Unable to Report?
(Select all that apply)

- ☒ Not Applicable, data reported above
- ☐ Information is not collected at Admission
- ☐ Information is not collected at Discharge
- ☐ Information not collected by categories requested
- ☐ State collects information on the indicator area but utilizes a different measure
- ☐ Other: Specify

State Description of Alcohol Use Data Collection (Form T4)

GOAL

To reduce substance abuse to protect the health, safety, and quality of life for all.

MEASURE

The change of all clients receiving treatment who reported abstinence at discharge.

STATE CONFORMANCE TO INTERIM STANDARD

States should detail exactly how this information is collected. Where data and methods vary from interim standard, variance should be described.

State collects admission data.

YES ☒ NO ☐

State collects discharge data.

YES ☒ NO ☐

State collects admission and discharge data on alcohol use that can be reported using TEDS definitions.

YES ☒ NO ☐

State reported data using data other than admission and discharge data.

YES ☐ NO ☒

State reported data using administrative data.

YES ☐ NO ☒

OMB No. 0930-0080 Approved: 8/26/2004 Expires: 08/31/2007

DATA SOURCE(S)	Source(s):	Rhode Island uses the "client information system" which collects TEDS information from our treatment providers

DATA ISSUES

Issues: Data system only collect one "substance of abuse" at discharge, but three at admission.
No "within past 30 days" restriction is placed on identified "substances of abuse."

OMB No. 0930-0080 Approved: 8/26/2004 Expires: 08/31/2007

DATA PLANS IF DATA IS NOT AVAILABLE	State should provide time-framed plans for capturing employment status data on all clients, if data is not currently available. Plans should also discuss barriers, resource needs and estimates of cost.

OMB No. 0930-0080 Approved: 8/26/2004 Expires: 08/31/2007

State:
Rhode Island

Reporting Period:
From 7/1/2005 To 6/30/2006

FORM T5 - PERFORMANCE MEASURE
CHANGE IN ABSTINENCE - OTHER DRUG USE (From Admission to Discharge)

Drug Abstinence - Clients with no drug use (all clients regardless of primary problem) (use Any Drug Use in last 30 days field) at admission vs. discharge.	Admission Clients (T1)	Discharge Clients (T2)	Absolute/Relative Change
Number of clients abstinent from illegal drugs [numerator]	2,763	8,805	
Total number of clients with non-missing values on 'used any drug' variable [denominator]	12,301	12,240	
Percent of clients abstinent from drugs	22.46%	71.94%	49.47% / 220.26%

OMB No. 0930-0080 Approved: 8/26/2004 Expires: 08/31/2007

THE SECTION BELOW SHOULD BE COMPLETED AT THE TIME DATA IS ENTERED IN THE TABLE ABOVE

T5.1
What is the source of data for this table? (Select all that apply)

- ☐ Client Self Report confirmed by another source.--> If checked, select one confirmation source.
- ☒ Client Self Report
- ☐ Administrative Data Source
- ☐ Other: Specify
- ☐ Urinalysis, blood test or other biological assay
- ☐ Collateral source
- ☐ Other: Specify

T5.2
How is Admission/Discharge Basis defined? (Select one)

- ☐ Admission is on the first date of service, prior to which no service has been received for 30 days AND Discharge is on the last date of service, subsequent to which no service has been received for 30 days.
- ☒ Admission is on the first date of service in a Program/Service Delivery Unit AND Discharge is on the last date of service in a Program/Service Delivery Unit
- ☐ Other: Specify

T5.3
How was the discharge data collected? (Select all that apply)

- ☒ Not Applicable, data reported on form is collected at time period other than discharge --> Specify:
  - ☐ In-Treatment data days post admission OR ☐ Follow-up data months Post ☐ admission OR ☐ discharge
  - ☐ Other: Specify
- ☒ Discharge data is collected for the census of all (or almost all) clients who were admitted to treatment
- ☐ Discharge data is collected for a sample of all clients who were admitted to treatment
- ☐ Discharge records are directly collected (or in the case of early dropouts) are created for all (or almost all) clients who were admitted to treatment
- ☐ Discharge records are NOT completed for some clients who were admitted to treatment
  Specify proportion of admitted clients with a discharge record: %

T5.4
Was the admission and discharge data linked? (Select all that apply)

- ☒ Yes, all clients at admission were linked with discharge data using a Unique Client ID (UCID).
  Select type of UCID:
  - ☐ Master Client Index or Master Patient Index, centrally assigned
  - ☐ Social Security Number
  - ☐ Unique client ID based on fixed client characteristics (such as DOB, gender, partial SSN, etc.)
  - ☐ Some other Statewide unique ID
  - ☒ Provider-entity-specific unique ID
- ☐ No, State Management Information System does not utilize a UCID that allows comparison of admission and discharge data on a client specific basis (data developed on a cohort basis) or State relied on other data sources for post admission data
- ☐ No, admission and discharge records were matched using probabilistic record matching

OMB No. 0930-0080 Approved: 8/26/2004 Expires: 08/31/2007

T5.5
Why are you Unable to Report?
(Select all that apply)

- ☒ Not Applicable, data reported above
- ☐ Information is not collected at Admission
- ☐ Information is not collected at Discharge
- ☐ Information not collected by categories requested
- ☐ State collects information on the indicator area but utilizes a different measure
- ☐ Other: Specify

OMB No. 0930-0080 Approved: 8/26/2004 Expires: 08/31/2007

State Description of Other Drug Use Data Collection (Form T5)

GOAL

To reduce substance abuse to protect the health, safety, and quality of life for all.

MEASURE

The change in all clients receiving treatment who reported abstinence at discharge.

STATE CONFORMANCE TO INTERIM STANDARD

States should detail exactly how this information is collected. Where data and methods vary from interim standard, variance should be described.

State collects admission data.

YES ☒ NO ☐

State collects discharge data.

YES ☒ NO ☐

State collects admission and discharge data on other drug use that can be reported using TEDS definitions.

YES ☒ NO ☐

State reported data using data other than admission and discharge data.

YES ☐ NO ☒

State reported data using administrative data.

YES ☐ NO ☒

DATA SOURCE(S)	Source(s):	Rhode Island uses the "client information system" which collects TEDS information from our treatment providers

DATA ISSUES

Issues: Data system only collect one "substance of abuse" at discharge, but three at admission.
No "within past 30 days" restriction is placed on identified "substances of abuse."

OMB No. 0930-0080 Approved: 8/26/2004 Expires: 08/31/2007

DATA PLANS IF DATA IS NOT AVAILABLE	State should provide time-framed plans for capturing employment status data on all clients, if data is not currently available. Plans should also discuss barriers, resource needs and estimates of cost.

OMB No. 0930-0080 Approved: 8/26/2004 Expires: 08/31/2007

State:
Rhode Island

Reporting Period:
From 7/1/2005 To 6/30/2006

FORM T6 - PERFORMANCE MEASURE
CHANGE IN SOCIAL SUPPORT OF RECOVERY (From Admission to Discharge)

Social Support of Recovery - Clients participating in self-help groups, support groups (e.g., AA, NA, etc.) (prior 30 days) at admission vs. discharge	Admission Clients (T1)	Discharge Clients (T2)	Absolute/Relative Change
Number of clients with one or more such activities (AA NA meetings attended, etc.) [numerator]	0	0	
Total number of Admission and Discharge clients with non-missing values on social support activities [denominator]	0	0	
Percent of clients participating in social support activities			0.00% / 0.00%

OMB No. 0930-0080 Approved: 8/26/2004 Expires: 08/31/2007

THE SECTION BELOW SHOULD BE COMPLETED AT THE TIME DATA IS ENTERED IN THE TABLE ABOVE

T6.1
What is the source of data for this table? (Select all that apply)

- ☐ Client Self Report
- ☐ Administrative Data Source
- ☐ Other: Specify

T6.2
How is Admission/Discharge Basis defined? (Select one)

- ☒ Admission is on the first date of service, prior to which no service has been received for 30 days AND discharge is on the last date of service, subsequent to which no service has been received for 30 days.
- ☐ Admission is on the first date of service in a Program/Service Delivery Unit AND Discharge is on the last date of service in a Program/Service Delivery Unit
- ☐ Other: Specify

T6.3
How was the discharge data collected? (Select all that apply)

- ☐ Not Applicable, data reported on form is collected at time period other than discharge --> Specify:
  - ☐ In-Treatment data days post admission OR ☐ Follow-up data months Post ☐ admission OR ☐ discharge
  - ☐ Other: Specify
- ☐ Discharge data is collected for the census of all (or almost all) clients who were admitted to treatment
- ☐ Discharge data is collected for a sample of all clients who were admitted to treatment
- ☐ Discharge records are directly collected (or in the case of early dropouts) are created for all (or almost all) clients who were admitted to treatment
- ☐ Discharge records are NOT completed for some clients who were admitted to treatment
  Specify proportion of admitted clients with a discharge record: %

T6.4
Was the admission and discharge data linked? (Select all that apply)

- ☐ Yes, all clients at admission were linked with discharge data using a Unique Client ID (UCID).
  Select type of UCID:
  - ☐ Master Client Index or Master Patient Index, centrally assigned
  - ☐ Social Security Number
  - ☐ Unique client ID based on fixed client characteristics (such as DOB, gender, partial SSN, etc.)
  - ☐ Some other Statewide unique ID
  - ☐ Provider-entity-specific unique ID
- ☐ No, State Management Information System does not utilize a UCID that allows comparison of admission and discharge data on a client specific basis (data developed on a cohort basis) or State relied on other data sources for post admission data
- ☐ No, admission and discharge records were matched using probabilistic record matching

OMB No. 0930-0080 Approved: 8/26/2004 Expires: 08/31/2007

T6.5
Why are you Unable to Report?
(Select all that apply)

- ☐ Not Applicable, data reported above
- ☒ Information is not collected at Admission
- ☒ Information is not collected at Discharge
- ☐ Information not collected by categories requested
- ☐ State collects information on the indicator area but utilizes a different measure
- ☐ Other: Specify

State Description of Social Support of Recovery Data Collection (Form T6)

GOAL

To improve clients' participation in social support of recovery activities to reduce substance abuse to protect the health, safety, and quality of life for all.

MEASURE

The change in all clients receiving treatment who reported participation in one or more social and or recovery support activity at discharge.

STATE CONFORMANCE TO INTERIM STANDARD

States should detail exactly how this information is collected. Where data and methods vary from interim standard, variance should be described.

State collects admission and discharge data on social support of recovery that can be reported using definitions provided as follows:

Participation in social support of recovery activities are defined as attending self-help, attending religious/faith affiliated recovery or self help groups, attending meetings of organizations other than the organizations described above or interactions with family members and/or friends supportive of recovery.

YES ☐ NO ☒

State reported data using data other than admission and discharge data.

YES ☐ NO ☒

State reported data using administrative data.

YES ☐ NO ☒

OMB No. 0930-0080 Approved: 8/26/2004 Expires: 08/31/2007

DATA SOURCE(S)	Source(s):	Rhode Island uses the "client information system" which collects TEDS information from our treatment providers.

DATA ISSUES

Issues: Specific social support information is not a part of the data set that is used to capture TEDS information. Rather, we ask if the client has been informed of supportive services. We are not capable of tracking participation in anonymous self help supportive groups.

OMB No. 0930-0080 Approved: 8/26/2004 Expires: 08/31/2007

DATA PLANS IF DATA IS NOT AVAILABLE	State should provide time-framed plans for capturing employment status data on all clients, if data is not currently available. Plans should also discuss barriers, resource needs and estimates of cost. Plans are in the discussion stages.

OMB No. 0930-0080 Approved: 8/26/2004 Expires: 08/31/2007

State:
Rhode Island

FORM T7: RETENTION

Length of Stay (in Days) of Clients Completing Treatment

Length of Stay			
LEVEL OF CARE	**AVERAGE**	**MEDIAN**	**STANDARD DEVIATION**
DETOXIFICATION (24 HOUR CARE)			
1. Hospital Inpatient	**0**	**0**	**0**
2. Free-standing Residential	**5.94**	**6**	**10.4**
REHABILITATION / RESIDENTIAL			
3. Hospital Inpatient	**34.8**	**15**	**57.4**
4. Short-term (up to 30 days)	**13.4**	**12**	**9.9**
5. Long-term (over 30 days)	**103**	**82**	**87**
AMBULATORY (OUTPATIENT)			
6. Outpatient	**111.3**	**83**	**118.4**
7. Intensive Outpatient	**57.8**	**37**	**67.4**
8. Detoxification	**134.1**	**90**	**201.1**
9. Methadone	**530.4**	**214**	**805.8**

Form T7 Footnotes
Includes information on all clients who were discharged, regardless of reason for discharge.

State:
Rhode Island

Reporting Period:
From 7/1/2005 To 6/30/2006

Prevention Form P1
NUMBER OF PERSONS SERVED

OMB No. 0930-0080 Approved: 8/26/2004 Expires: 08/31/2007

Persons served in Block Grant funded services include all persons served in prevention programs that receive all or part of their funding through the SAPT Block Grant.

AGE	TOTAL	SINGLE SERVICES	RECURRING SERVICES	RACE/ETHNICITY	TOTAL	SINGLE SERVICES	RECURRING SERVICES	GENDER	TOTAL	SINGLE SERVICES	RECURRING SERVICES
0-4	**9**	**8**	**1**	American Indian / Alaska Native	**0**	**0**	**0**	MALE	**5448**	**2100**	**3348**
5-11	**112**	**22**	**90**	Asian	**260**	**0**	**260**	FEMALE	**5743**	**1081**	**4662**
12-14	**4525**	**35**	**4490**	Black / African American	**806**	**0**	**806**				
15-17	**2804**	**18**	**2786**	Native Hawaiian / Other Pacific Islander	**0**	**0**	**0**				
18-20	**370**	**110**	**260**	White	**4431**	**0**	**4431**				
21-25	**458**	**212**	**246**	More than one Race	**561**	**0**	**561**				
26-44	**215**	**159**	**56**	Unknown	**3646**	**2205**	**1441**				
45-64	**465**	**369**	**76**	Total	**9704**	**2205**	**7499**				
65+	**19**	**14**	**5**	Not Hispanic Or Latino	**6494**	**0**	**6494**				
				Hispanic Or Latino	**1516**	**0**	**1516**				
Total	**8977**	**947**	**8010**	**Total**	**8010**	**0**	**8010**	**Total**	**11191**	**3181**	**8010**

Form P2

State:
Rhode Island

Reporting Period:
From 7/1/2005 To 6/30/2006

PREVENTION FORM P2
NUMBER OF EVIDENCE-BASED PROGRAMS, PRACTICES, AND POLICIES

Programs include all prevention programs, practices, policies, and strategies that receive all or part of their funding through the SAPT Block Grant.

1.List NREPP programs or practices below.

Program Name and Source	Universal Populations	Selective Populations	Indicated Populations	Total
Life Skills Training	1	1	0	2
Strengthening Families Program	1	0	0	1
Creating Lasting Family Connections	0	1	0	1
Incredible Years	1	1	0	2
Leadership and Resiliency	0	0	1	1
Project Success	0	1	0	1
Subtotal	3	4	1	8

2.List programs or practices from lists recommended by other Federal agencies.

Program Name and Source	Universal Populations	Selective Populations	Indicated Populations	Total
I Can Problem Solve	0	1	0	1
Subtotal	0	1	0	1

3.List peer-reviewed journal-evidenced programs, practices, and policies (attach journal citation).

Program Name and Source	Universal Populations	Selective Populations	Indicated Populations	Total

4.List the names of other evidence-based programs, practices, and policies (attach source and type of evidence).

Program Name and Source	Universal Populations	Selective Populations	Indicated Populations	Total
Laotian and Cambodian Substance Abuse Prevention Program	0	1	0	1
Parents are Teachers Program	0	1	0	1
Rhode Island Teen Institute	1	0	0	1
Raising A Thinking Child	0	1	0	1
RiverzEdge Arts Project	0	1	0	1
Dare To Be You Adaptation	0	1	0	1
Subtotal	1	5	0	6

5.List the names and sources of other non-evidence-based programs, practices, and policies (attach additional information on the program, practice, or policy).

Program Name and Source	Universal Populations	Selective Populations	Indicated Populations	Total
Help Line and Resource Directory	1	0	0	1
South Kingstown Physicians Initiative	1	0	0	1
Rhode Island Student Assistance Program	0	1	0	1
Drug and Alcohol Treatment Association (DATA) Training and Education Program	1	0	0	1
Subtotal	3	1	0	4

TOTALS

GRAND TOTAL all programs, practices and policies	**19**
Percent Evidence-Based (sections 1 - 4 above)	**79%**
Percent Non-Evidence-Based (section 5 above)	**21%**

Form P3

State:
Rhode Island

Reporting Period:
From To

PREVENTION FORM P3
PERCEPTION OF RISK/HARM OF, AND UNFAVORABLE ATTITUDES TOWARD SUBSTANCE USE BY THOSE UNDER AGE 21

For perception of risk/harm, report the number and percent of the State population who responded “slight risk”, “moderate risk” or “great risk” (add the three categories).

For unfavorable attitudes, report the number and percent of the State population who responded “somewhat disapprove” or “strongly disapprove” (add the two categories).

Indicator	Drug	No. of Respondents	Percent of Respondents
Perception of Risk/Harm of Substance Use	**Alcohol**	**0**	**0**
	Cigarettes	**0**	**0**
	Marijuana	**0**	**0**
Unfavorable Attitudes Toward Substance Use	**Alcohol**	**0**	**0**
	Cigarettes	**0**	**0**
	Marijuana	**0**	**0**

OMB No. 0930-0080 Approved: 8/26/2004 Expires: 08/31/2007

Form P4

State:
Rhode Island

Reporting Period:
From To

PREVENTION FORM P4
USE OF SUBSTANCES DURING THE PAST 30 DAYS

Report the number and percent of the State population who responded having used at least one or more times in the past 30 days.

OMB No. 0930-0080 Approved: 8/26/2004 Expires: 08/31/2007

Drug		12-17 year olds	18-25 year olds	>26 year olds	Total
Alcohol	**N**				
	%				
Tobacco	**N**				
	%				
Marijuana	**N**				
	%				
Cocaine/Crack	**N**				
	%				
Stimulants	**N**				
	%				
Inhalants	**N**				
	%				
Heroin	**N**				
	%				

Rhode Island

INSERT OVERALL NARRATIVE:

INSERT OVERALL NARRATIVE:

State applicants should include a discussion of topics relevant to outcome reporting in general. This would include topics mentioned in instructions above as well as any additional information (e.g., data infrastructure needs) that the State deems important.

PREVENTION INFORMATION MANAGEMENT SYSTEM

The Department implemented a management information system in FY 2002 to track prevention services. The system is a web-based system developed by KIT Solutions called the Performance Based Prevention System (PBPS).

This outcome-based system includes a planning module that is in alignment with the risk and protective factor framework presently used by the Department. The objectives required in the planning module are based on achieving intermediate and outcome objectives rather than on tracking individual activities. Providers are required to document incidence, prevalence, and risk factor levels that inform their selection of outcome and intermediate objectives. During FY 2004, prevention and technical support staff from the Department worked with KIT Solutions to incorporate an objective builder into the planning module to make constructing objective statements easier for providers.

Currently, the Department is working cooperatively with KIT Solutions to make the PBPS compatible with the Strategic Planning Framework State Incentive Grant (SPF SIG) data collection requirements.

The Department continues to work on refinement of the web-based PBPS to track prevention service data and program outcomes, including the development of a module to capture information about the work of community coalitions. The coalition module will include a logic model, capacity development plan, evaluation plan, and a report mechanism linked to the logic model.

The Department will continue to base its program planning and implementation on the IOM spectrum of preventive interventions, risk and protective factors, and the Strategic Prevention Framework. The Department supports the use of evidence-based, culturally appropriate programs, policies, and practices.

The Department will continue to collaborate with the University of RI's Community Research and Services Team to analyze the current National Outcome Measures of the SAPT Block Grant to determine the human and material resources the Department will need to comply with future reporting requirements.

Rhode Island

Appendix A - Additional Supporting Documents (Optional)

Appendix A - Additional Supporting Documents (Optional)

No additional documentation is required to complete your application, besides those referenced in other sections. This area is strictly optional. However, if you wish to add extra documents to support your application, please attach it (them) here. If you have multiple documents, please 'zip' them together and attach here.

Statewide Evaluation: Replicating Science-based Substance Abuse Prevention Programs[1]

November 2005

Rhode Island Department of Mental Health Retardation and Hospitals

Division of Behavioral Healthcare Services

Prepared by the[2]

Community Research and Services Team at the University of Rhode Island

[1] The RI Department of Mental Health, Retardation, and Hospitals with funding from the Substance Abuse and Mental Health Services Administration (SAMHSA) Substance Abuse Prevention and Treatment (SAPT) Block Grant provided support for the collection of the data on which this report is based via a contract for Statewide Evaluation of the Replication of Science-based Programs.

[2] Community Research and Services Team, Department of Psychology, University of Rhode Island, Providence Campus, Room 236, 80 Washington Street, Providence, RI 02903-1803. (401) 277-5318

EXECUTIVE SUMMARY

This four-year project investigated the effectiveness of three well-researched "model" programs for the prevention of alcohol, tobacco, and other drug abuse. Two of the programs were designed to be delivered in middle school classrooms over a number of weekly sessions: Life Skills Training (LST) and Project Northland (PN). The third program was designed to be delivered to parents/guardians and their middle school child: Iowa Strengthening Families Program (ISFP). With funding from the Division of Behavioral Healthcare Services, RI Department of Mental Health, Retardation and Hospitals, five community-based organizations mounted these interventions in eight middle schools spread across seven school districts in RI. At each site one of the classroom curricula was combined with the family-oriented program for implementation over a three-year period with one cohort of middle school students.

Did the programs reach the intended target population?

- 1,326 students had received three years of exposure to one of the classroom prevention curricula at the time we conducted outcome analyses. There is enough statistical power to detect even modest effects for both of the classroom curricula.

- The Iowa Strengthening Families Program had 98 youth and 106 parents for whom we could analyze results, representing only 7.4% of the classroom treatment sample

.

- Eighth graders in our outcome analyses were approximately 50% female, and varied across the schools, with program-level subgroups ranging from 67.5% to 83.6% white, 55.3% to 79.7% ineligible for subsidized lunch, 71.5% to 79.7% in two-parent families, and 57.1% to 63.5% with grades mostly B or better.

- The non-random way in which schools chose the curricula makes any competitive comparisons of the two classroom curricula suspect; for example, 75.8% of the Project Northland treatment group paid full price for their lunches, whereas only 55.3% of the Life Skills Training treatment group did so.

- Students in the ISFP program were more likely to be white and less likely to be in two-parent families than the youth treatment cohort as a whole.

Were the programs delivered with fidelity?

- All three programs were delivered with relatively good fidelity: ISFP (94.9%), PN (88.4%), and LST (80.1%).

Were our outcome measures effective?

- We measured performance on Intermediate Objectives most likely to show direct effects of the programs (e.g. perceived peer disapproval for use, attitudes toward drug use, drug refusal skills, peer normative beliefs, intentions to use drugs, family attachment, and parental monitoring. Psychometric properties were reasonable for our sample.

- We measured Outcome Objectives required by RIMHRH (30-day prevalence of substance use, age of initiation of use, and problem drinking). We particularly examined alcohol use as an appropriate indicator for this age group.

Did the programs achieve intermediate objectives by eighth grade?

- When we compared our 8th grade treatment group to untreated 8th graders from the same schools, there were highly significant positive differences; the largest differences were for Favorable Attitudes Toward Drug Use and Drug Use Intentions (both lower for our treatment group).

- All four intermediate objectives specific to Project Northland showed modest but significant effects in the right direction, including effects on youth perception of parents (quality of parent communication and rule enforcement for ATOD use).

- For Life Skills Training, three of five intermediate outcome measures showed modest positive effects (higher drug refusal skills, reduced pro-drug attitudes, and lower perceived peer norms).

- For ISFP, parents indicated significant improvement over time on all five outcomes but only one intermediate outcome showed significant positive change for both parents and youth in ISFP: there was a significant increase in "Limit Setting and Monitoring." This is worth celebrating, as it is an important protective factor.

Did the programs achieve effects on substance use outcomes?

- For 30-day prevalence of alcohol use, probably the most widely chosen indicator for studies with this age group, both programs produced substantial effects (45% lower alcohol use than for the comparison group) that were highly significant and did not differ between the two classroom curricula.

- SALT data confirmed this finding.

- For initiation of alcohol use during the three years of the programs, there was a significant effect when both programs were combined but this was due to the substantial effect of Project Northland (42% lower initiation than the comparison group) and did not show up for the Life Skills Training intervention.

- Both programs had a significant effect on problem drinking. Eighth grade youth in the comparison group had a 10.9% rate of problem drinking, while the eighth grade youth in the treatment group had a 6.5% rate. This represents a 40% lower rate.

- The Iowa Strengthening Families Program did not have a significant added effect. However, there are important qualifications for this conclusion, including the small sample size and the weak self-report measure we had of participation in ISFP for these analyses.

Final conclusions

- If the goal is decreasing initiation of use (any experimentation with alcohol) PN is a more promising choice, especially for non-white and lower S.E.S. students.

- If reducing 30-day prevalence (regular use of alcohol over time) is the goal, both programs did very well and LST was especially effective for white and higher S.E.S. students.

- For reducing problem drinking (three or more drinks at one time in the past two weeks) both programs did very well.

Acknowledgements

The CRST thanks superintendents and principals in participating school districts and schools for allowing us to evaluate the programs offered in their schools. Their interest and support were essential to the project's success. We also want to thank the Community Substance Abuse Prevention Task Forces and Student Assistance Counselors who facilitated the survey administration process in some communities, as well as the teachers and other providers who gathered information from students and some of their families, who provided information on a daily basis in the form of fidelity checklists and who provided self-evaluation data regarding their training in the model program curriculum. We also thank the vendor agencies and their dedicated staff who diligently fulfilled active roles beyond the scope of this project and those who worked behind the scenes. Continued concern and cooperation at the local level was essential to the success of the Science-based Demonstration Project. We hope the outcome of this project will justify current and future participation.

We especially thank the thousands of students who responded voluntarily to participate in taking the youth survey. Their willingness to provide us with three years of information about themselves is greatly appreciated. We thank parents and their youth who participated in the family-based program for providing information as well.

The Rhode Island Department of Mental Health, Retardation and Hospitals, Division of Behavioral Healthcare Services, provided support for this project, with funding from the U.S Center for Substance Abuse Prevention.

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Background for this project

Overview

Over the past two decades there has been a move toward an increased emphasis on accountability of human service programs in the United States. During this time public and private sectors funded research programs that have been developing a science of prevention. The Division of Behavioral Healthcare Services (DBHS), Rhode Island Department of Mental Health, Retardation, and Hospitals funded demonstration projects that combined replications of three "science-based" model programs for the prevention of alcohol, tobacco, marijuana, and other drug abuse for youth ages 10-14 and a portion of their families. The Division awarded contracts to five community-based organizations in documented partnerships with one or more middle schools (totaling eight middle schools). The Community Research and Services Team (CRST), based in the Psychology Department at the University of Rhode Island, served as the statewide evaluators.

Scope of Work Performed

As the statewide evaluators, the CRST provided direction and guidance to the vendor agencies in the management of their evaluations, prepared and supplied pre-post instruments used by vendors to measure intermediate and ultimate outcomes for the programs and a tool for monitoring the fidelity of each of the programs, provided technical assistance in program evaluation to the vendors through a designated liaison, coded and analyzed the data collected by the local vendors, provided feedback to the vendors in the form of data summaries, and compiled outcome data across the demonstration projects to prepare this final report.

Description of the Prevention Programs Used

The funded vendors chose to implement one of two youth-oriented prevention curricula for their projects. The Life Skills Training (LST) Program is a school-based tobacco, alcohol, and drug abuse prevention program for adolescents in grade six with booster sessions continuing in grades seven and eight. Project Northland (PN) is a community-wide program (with peer-led school-based curriculum, parent involvement, and a community-wide policy change component) sequentially designed for presentation to students in grades six through eight. Each of the funded vendors elected to implement the Iowa Strengthening Families Program (ISFP) as a family-based prevention program that focuses on improving parent-child relationships through changing family dynamics and helping families work together as a unit. A more detailed description of each program can be found in Appendix A.

Objectives and Logic Models

DBHS specified the following outcome objectives for youth reached by the funded demonstration projects:

Objective 1: The percent of treated eighth graders who report initiation of tobacco and alcohol use will be 10% lower than an untreated comparison group by Year 3 of the project;

Objective 2: The percent of treated eighth graders who report current use of tobacco, alcohol, marijuana and inhalants (30 day prevalence) will be 10% lower than an untreated comparison group by Year 3 of the project;

Objective 3: The percent of treated eighth graders who report current problem drinking will be 10% lower than an untreated comparison group by Year 3 of the project.

In addition to the DBHS-required outcome objectives, the selected programs have documented effects on intermediate objectives. The CRST, in conjunction with the local agencies, identified relevant intermediate objectives and selected promising measures for these objectives, considering the core measures recommended by CSAP and the locally available sources for comparison, such as the Youth Tobacco Survey and the SALT. Some measures were shared between LST and PN and others were specific to the components of one of the programs. Figures 1, 2 and 3 present program-specific logic models that provide descriptions of these objectives.

Statewide Evaluation Design

The statewide outcome evaluation design made use of self-report questionnaires for youth in the LST and PN programs. Youth and parents who participated in the family based program, ISFP, were also measured using pre and post survey questionnaires. Copies of the instruments used can be viewed in Appendix B. Surveys were administered before and after each multi-session year of the LST and PN curriculum, tracking the same cohort from sixth to eighth grade. A unique identifier code known only to the participant was used to track individual respondents over time (see Appendix C for the matching protocol, and a paper discussing this procedure). This anonymous technique of matching data allowed for repeated measures analyses and examination of attrition effects. A sample consisting of all eighth graders from the same schools in year one served as a comparison group. These students responded to the survey, but were not exposed to the curriculum. Data from the comparison group were collected in spring 2003. An investigation of 30-day prevalence for alcohol use by month for the comparison group indicated periods of increased reports of use and non-use. In order to provide stable measurements for comparison, the treatment groups responded to the same instruments at approximately the same time of year as their comparison group for their final post-test when they reached the eighth grade in 2005. The effects of participation in ISFP are examined as an enhancement to the classroom curricula. In addition to changes over time for students, comparisons are made between the eighth grade cohort and eighth grade comparison group, between LST and PN, between participants with and without exposure to the ISFP, and results are also compared to state trends obtained from the SALT. Effects are analyzed controlling for demographic differences, and specific demographic factors are examined to investigate the effectiveness of programs for diverse groups.

Four of the five participating vendors elected to use passive consent. Prior to implementation, letters written by each vendor were mailed to the parents of all sixth and eighth grade students in each of the supporting schools. Parents were directed to return the letters if they did not want their children to participate in the survey. Participation in the survey was voluntary. Even if parents did not return the letters indicating their refusal, students were given the opportunity to assent to or decline completing the survey. The agency that elected to use active consent followed the same protocol as the others; however, the parents of each student in their school needed to return the letter indicating approval for their children to respond to the survey. Youth of parents who did not return the letter did not complete the surveys. Parents and youth participating in the ISFP gave oral agreement to participate in the survey at the first meeting.

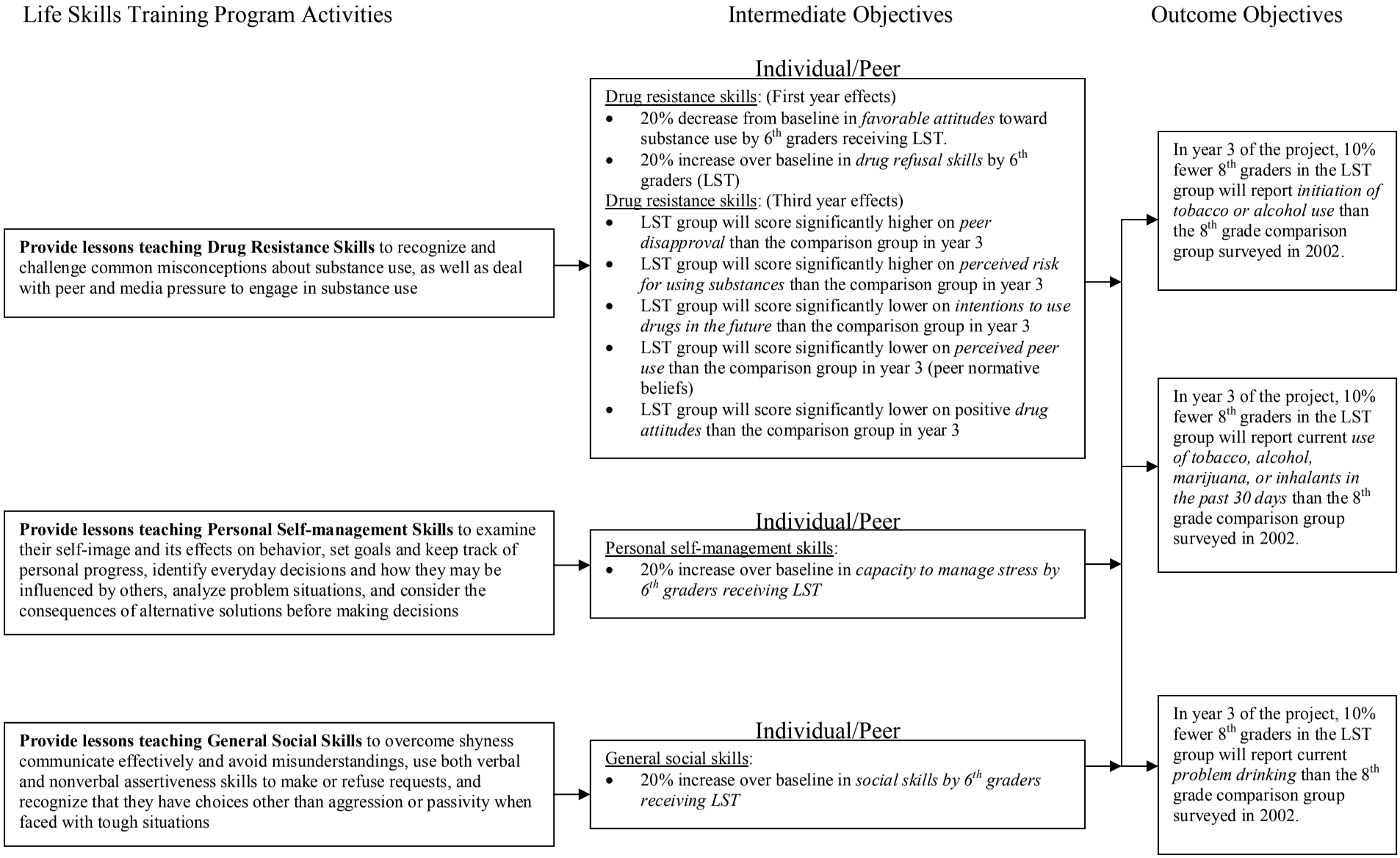

Figure 1. Life Skills Training Logic Model

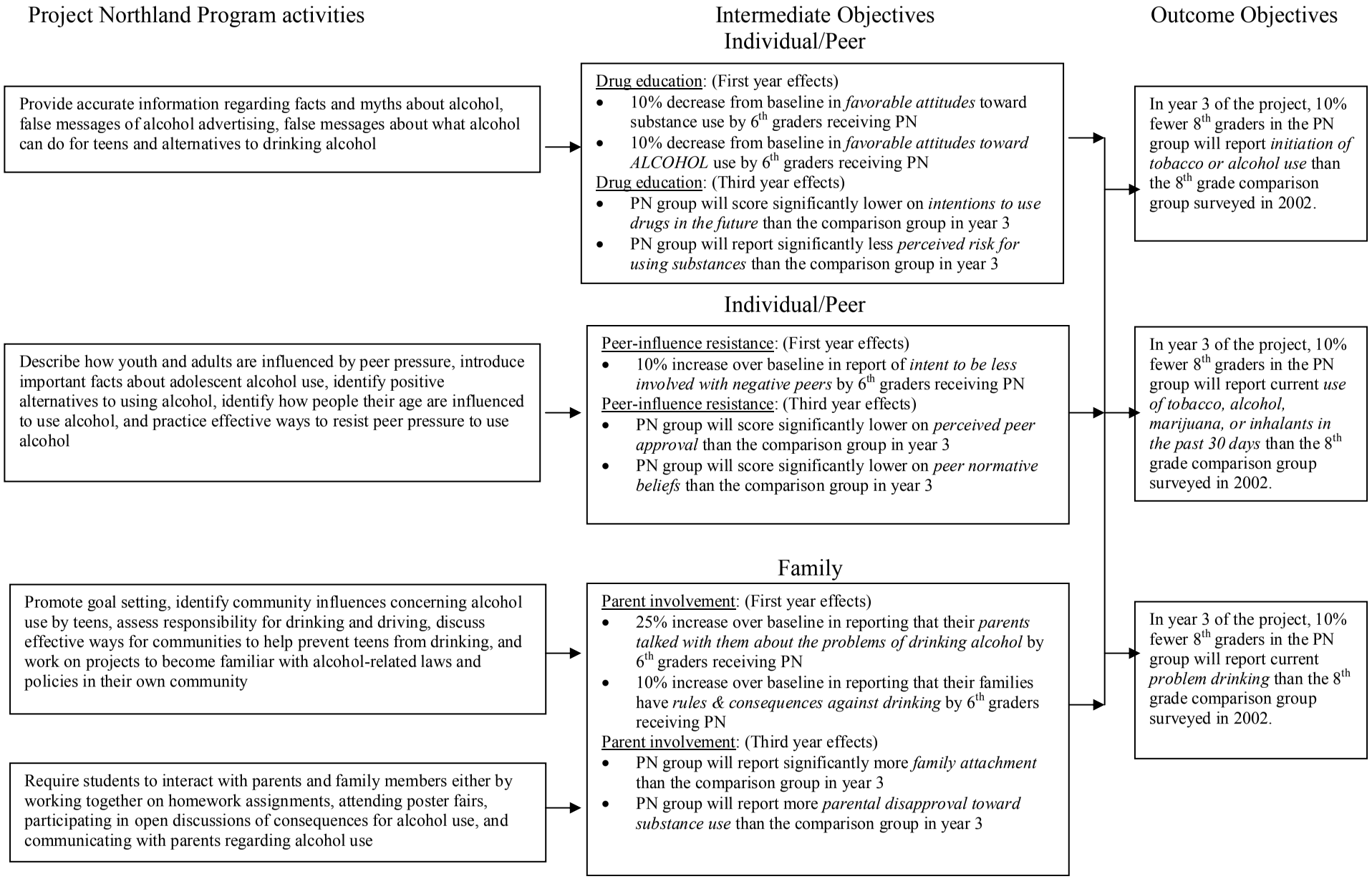

Figure 2. Project Northland Logic Model

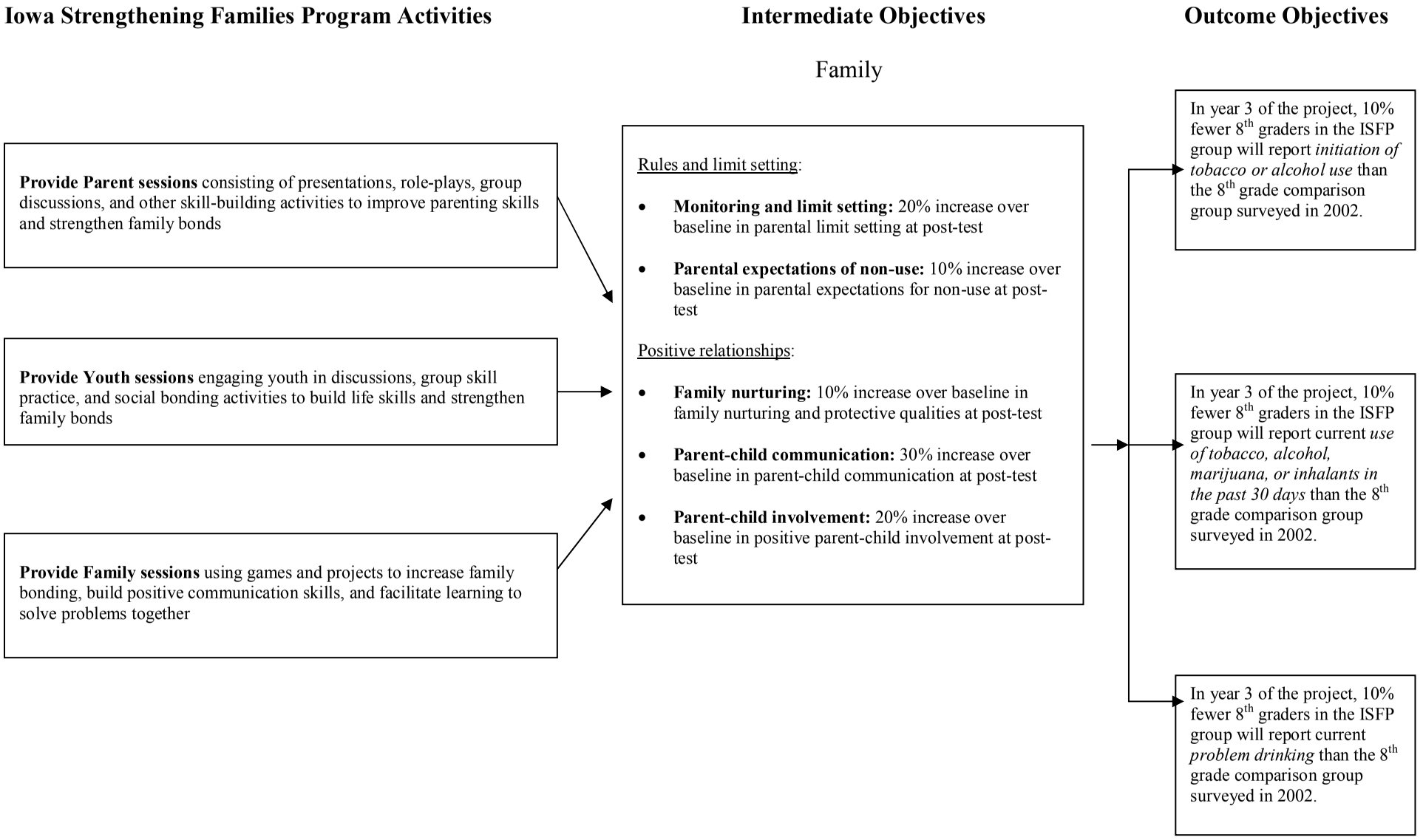

Figure 3. Iowa Strengthen Families Program Logic Model

Process Evaluation of the Program

In this section we will report on the characteristics of youth and parents who participated in the programs, the fidelity of treatment, our evolving process for coordinating the evaluation and the initial training of program staff in curriculum delivery.

Demographic characteristics of the samples used in analyses

PN and LST

Table 1 provides information on demographic characteristics, contrasting the eighth grade comparison group with the eighth grade treatment group (the entire sample receiving 3 years of the prevention curriculum). Youth in the treatment cohort who did not receive the program in its entirety or who left the school were not surveyed in the eighth grade. The comparison group is comprised of 1443 respondents, while the treatment group provided data from 1326 participants. Treatment and comparison group sample sizes vary among the schools receiving the program; on average the Project Northland school comparison samples are bigger than the treatment group samples, while the reverse is true for the Life Skills Training schools. The percent of female participants in each school differed slightly, but gender was represented similarly for the treatment and comparison groups. Age was quite similar across schools and groups, although students at Calcutt Middle School (CMS) in Central Falls were slightly older on average. The percent of white students was similar for comparison and treatment groups, though slightly higher for the comparison group. CMS was noticeably different from all of the other schools in the project in race composition (32% White in the comparison group and 21% in the treatment group) and eligibility for free or partial subsidy for school lunch (3.7% Full pay in the comparison group and 1.2% in the treatment group), and this brought the overall averages for these characteristics down in the Life Skills sample.

Table 2 provides additional information on demographic characteristics, contrasting the matched sample (sixth graders in our treatment group whom we were able to track across seventh and eighth grades) with the unmatched sixth graders (those from whom we collected data at Time 1 but were unable to track through the subsequent two years). Participants we could not match were consistently lower in percent White, full pay lunch, coming from two-parent families, and obtaining grades of 'B' or better. As in the eighth grade samples described above, CMS contributed to a discrepancy between the Life Skills students and the Project Northland students on these characteristics.

ISFP

Table 3 provides information on demographic characteristics of the parent/care providers and youth participating in the family based program. Only those parents (66.3% of the total parent sample) and youth (76% of the total youth sample) who were present at both the pre- and post-tests for the initial 7-session intervention are included. Over the three years, 204 participants (106 parent/care providers and 98 youth) provided pretest and posttest data that we could successfully match. About three quarters of the parents were female (mostly mothers but also a few grandmothers). Our intention was to include only participants in our cohort and therefore we began by collecting data from the sixth graders in 2003 (55% of the sample) and continued in the following year with data from seventh graders (30%) and from eighth graders (15%) in year three. Note that these are non-overlapping groups of students whose families participated in the initial 7-session intervention during different years. Roughly 85% of parents were white; 60% did not qualify for subsidized lunch; 90% spoke English at home; the median years of education extended two years past high school; and about half were in 2-parent families. However, there was noteworthy variation between the schools on some of these demographic factors. Parents in Curtis Corner Middle School in South Kingstown (n = 13) and Pier Middle School in Narragansett (n = 9) were all White, while none of the parents of children in Calcutt Middle School in Central Falls (n = 6)

described themselves as White. A Spanish version of the parent survey was created and used in Central Falls for posttest due to the high percentage of parents who had difficulty with the English version. Although a majority of families from most of the schools paid full lunch, all parents from Central Falls received at least partial subsidy for their children's school lunch, and at J.F. Deering in W. Warwick 56% qualified for subsidy. In the initial classroom survey conducted in sixth grade, 78% said they were White and 75% said they were in 2-parent families. Thus, the families who chose to participate in ISFP were somewhat more likely to be White and less likely to be in 2-parent families than the youth treatment cohort as a whole. Anecdotal reports at liaison meetings indicated that a few divorced parents attended the sessions together. Of the 98 youth who were matched in the ISFP sample, 43% were female and the majority (75%) participated in the sixth grade.

Table 1. Demographics for 8th graders (2002) & 8th graders (2005) in Project Northland & Life Skills Training Program Schools							
School	**Demographic Characteristics for Treatment and Comparison Cohorts**						
Project Northland	Number Complete (N)	Female (%)	Age (Average)	White (%)	Full Pay Lunch (%)	Two-Parent Family (%)	Mostly B or Better (%)
Broad Rock Comparison	175	45.7	13.6	86.9	90.1	80.5	75.6
Broad Rock Treatment	142	55.3	13.6	89.4	87.3	84.4	70.4
Park View Comparison	272	56.1	13.6	74.6	72.7	66.4	48.3
Park View Treatment	160	45.1	13.9	59.4	59.5	71.2	41.2
Curtis Corner Comparison	155	49.4	13.6	91.0	93.5	82.5	68.4
Curtis Corner Treatment	161	42.1	13.5	92.5	90.1	83.9	82.6
J F Deering Comparison	235	53.7	13.5	86.8	70.8	75.3	45.9
J F Deering Treatment	206	53.2	13.5	85.0	69.3	75.5	54.3
Total (weighted) Comparison	837	52.0	13.6	83.6	79.7	74.8	57.1
Total (weighted) Treatment	669	49.0	13.6	81.6	75.8	78.4	61.4
Total Combined	**1506**	**50.5**	**13.6**	**82.6**	**77.7**	**76.6**	**59.2**
Life Skills Training							
Calcutt Comparison	142	65.2	14.4	32.1	3.7	65.9	44.4
Calcutt Treatment	171	54.3	13.6	20.5	1.2	53.3	59.1
Pier School Comparison	139	47.5	13.5	96.4	88.3	78.4	63.2
Pier School Treatment	93	48.3	13.7	92.5	88.9	80.2	65.9
Portsmouth Comparison	205	48.0	13.6	97.0	92.4	80.0	74.9
Portsmouth Treatment	215	46.4	13.5	92.6	89.5	84.4	76.2
Thompson Comparison	120	53.3	13.8	68.6	49.6	60.2	57.6
Thompson Treatment	178	48.0	13.6	69.1	48.3	69.0	51.1
Total (weighted) Comparison	606	53.0	13.8	76.0	62.2	72.4	61.6
Total (weighted) Treatment	657	49.2	13.6	67.5	55.3	71.5	63.5
Total Combined	**1,263**	**51.1**	**13.7**	**71.7**	**58.7**	**72.0**	**62.6**
Project Total (weighted)	**2,769**	**50.8**	**13.6**	**77.6**	**69.1**	**74.4**	**60.6**

Table 2. Sixth graders in the treatment cohort receiving Project Northland & Life Skills Training Program							
School	**Demographic Characteristics for Matched and Unmatched Youth**						
Project Northland	Number Complete (N)	Female (%)	Age (Average)	White (%)	Full Pay Lunch (%)	Two-Parent Family (%)	Mostly B or Better (%)
Broad Rock T1 T6 matched	134	57.9	11.2	88.8	86.5	85.1	91.0
Broad Rock T1 T6 unmatched	33	45.5	11.2	84.8	78.8	69.7	63.6
Park View T1 T6 matched	90	46.5	11.4	81.8	70.8	85.1	66.3
Park View T1 T6 unmatched	116	42.2	11.5	74.6	67.3	66.1	61.4
Curtis Corner T1 T6 matched	143	39.2	11.3	91.6	93.7	88.8	87.3
Curtis Corner T1 T6 unmatched	27	59.3	11.3	88.9	74.1	77.8	81.5
J F Deering T1 T6 matched	169	53.9	11.3	89.2	67.7	79.9	74.1
J F Deering T1 T6 unmatched	100	43.0	11.4	81.6	43.9	64.6	59.6
Total (weighted) Matched	536	49.7	11.3	88.5	79.9	84.4	80.5
Total (weighted) Unmatched	276	44.6	11.4	79.8	60.9	67.1	63.0
Total Combined	**812**	**47.1**	**11.4**	**84.1**	**70.4**	**75.8**	**71.8**
Life Skills Training							
Calcutt T1 T6 matched	85	61.0	11.6	23.5	1.2	61.2	64.5
Calcutt T1 T6 unmatched	77	60.8	11.6	20.8	0.0	59.7	65.7
Pier School T1 T6 matched	91	49.4	11.0	92.3	86.8	81.3	92.3
Pier School T1 T6 unmatched	30	58.6	11.0	90.0	73.3	50.0	72.4
Portsmouth T1 T6 matched	184	48.9	11.0	95.7	89.3	84.8	87.4
Portsmouth T1 T6 unmatched	34	35.3	11.0	88.2	93.8	79.4	84.4
Thompson T1 T6 matched	125	47.5	11.4	67.2	50.8	68.8	59.0
Thompson T1 T6 unmatched	70	42.9	11.5	64.3	37.7	45.7	40.0
Total (weighted) Matched	485	50.8	11.2	75.1	63.5	75.9	77.0
Total (weighted) Unmatched	211	50.4	11.4	55.9	38.0	56.9	61.1
Total Combined	**696**	**50.6**	**11.3**	**65.5**	**50.8**	**66.4**	**69.1**
Project Total (weighted)	**1,508**	**49.2**	**11.33**	**78.0**	**65.3**	**74.7**	**73.5**

Time 1 (T1) pretest grade 6 Time 6 (T6) posttest grade 8

Table 3. Participants in the Iowa Strengthening Families Program

School	Demographic Characteristics for Matched Parent & Youth								
ISFP PARENT	**Number Complete (N)**	**Female (%)**	**White (%)**	**Full Pay Lunch (%)**	**English at Home (%)**	**Median Years Education (%)**	**Married, Spouse absent (%)**	**Married Spouse Present (%)**	**Unmarried (%)**
Broad Rock matched	17	52.9	94.1	70.6	94.1	16.0	0	81.3	18.8
Calcutt matched	6	100.0	0.0	0.0	16.7	12.0	16.7	0	83.4
Park View matched	29	92.9	89.7	55.2	96.6	13.0	20.7	31	48.2
Curtis Corner matched	13	66.7	100.0	84.6	100.0	17.5	0	76.9	23.1
Pier School matched	9	66.7	100.0	77.8	100.0	15.5	0	42.9	57.1
Portsmouth matched	6	66.7	83.3	83.3	83.3	16.0	0	83.3	16.7
Thompson matched	8	100.0	62.5	62.5	87.5	16.0	0	50	50
J. F. Deering matched	18	72.2	88.9	44.4	88.9	12.0	16.7	33.3	50
Total (weighted) Matched	106	77.0	84.9	60.4	89.6	14.4	9.4	48.7	41.8

ISFP YOUTH	**Number Complete (N)**	**Female (%)**	**Student Grade**		
			6th	**7th**	**8th**
Broad Rock matched	12	58.3	100.0	0.0	0.0
Calcutt matched	9	50.0	44.4	22.2	33.3
Park View matched	35	37.1	77.1	8.6	14.3
Curtis Corner matched	8	50.0	100.0	0.0	0.0
Pier School matched	8	16.7	87.5	0.0	12.5
Portsmouth matched	5	40.0	100.0	0.0	0.0
Thompson matched	7	57.1	71.4	0.0	28.6
J. F. Deering matched	14	46.2	38.5	61.5	0.0
Total (weighted) Matched	98	43.1	74.9	13.9	11.2
Project Total (weighted)	**204**	**60.7**	**80.1**	**38.0**	**52.0**

Fidelity

We tracked the fidelity of implementation of the three programs with checklists completed by the prevention educator after each session of the curricula. These checklists were designed to reflect the activities specified by the curriculum for each session. See Appendix D for an example. Table 4 summarizes information on the educator-reported fidelity of implementation of the curricula using the post-session process checklists we provided. The first column (Year 1 sessions) of the ISFP curriculum contains the total percent of completion of the content calculated from all data for the initial 7 sessions over the three years of the project. These percentages combine data collected across all of the sessions for parents, children, and families. The ISFP curriculum was very high in fidelity across all of the sites (95%), suggesting that it worked well in terms of feasibility of implementation. The families who attended received a uniformly high "dose" of the program. For the classroom curricula, we aggregated across the entire set of sessions for each classroom, and then averaged across all the classrooms in each school. The classroom curricula were implemented with more variability across school, and it also appears that PN was likely to be more fully implemented on average (91.5%) than LST (77.3%) in year 1. This is consistent with the higher number of required sessions for LST (15 in the first year, vs. 7 for PN), and has been reflected in conversations during the monthly liaison meetings. In year 2 the PN curricula increased to eight lessons and the percentages dropped substantially (84.1%). In year 2 the LST curricula decreased to ten lessons, but there was difficulty with scheduling classes and overlap with other programs

Table 4. Program Fidelity (Percent of Content Covered)

Program Fidelity %

	ISFP		Project Northland			Life Skills Training		
School	Year 1 sessions	Booster sessions	Year 1	Year 2	Year 3			
Broad Rock	95.0*	90.1*	95.6	79.7	95.3			
Park View	90.8		79.7	83.6	83.7			
Curtis Corner	95.0*	90.1*	95.9	81.9	92.4			
J F Deering	96.3	93.7	94.7	91.3	86.9			
Total	**93.6**	**93.7**	**91.5**	**84.1**	**89.6**			
Grand Total	**93.6**			**88.4**				
	Year 1	Booster				Year 1	Year2	Year 3
Calcutt	86.2					80.9	75.1	84.8
Pier School	94.0	99.1				83.1	73.3	76.1
Portsmouth	96.0					75.3	64.8	98.2
Thompson	97.5					69.9	80.8	99.3
Total	**93.4**	**99.1**				**77.3**	**73.5**	**89.6**
Grand Total	**96.3**						**80.1**	
	Family-based program			**School-based program**				
Project Total	**94.9**			**84.3**				

*** Fidelity compiled across the two South Kingstown schools**

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and adherence to the program was compromised (73.5%). In year 3, fidelity in PN (89.6%) and LST (89.6%) schools improved resulting in the average participant in both programs receiving nearly 85% of the program across the three years.

Description of the monthly liaison meetings

The contracted role of the CRST was to coordinate a quantitative evaluation of the effectiveness of the three programs selected for implementation by the vendor agencies. In our role as the statewide evaluation team for the project, the CRST held monthly meetings over the duration of the project with staff liaisons from each of the five vendor agencies. Although the ostensible purpose of our evaluation was to draw statistical conclusions regarding program effectiveness, we found that another valuable type of learning took place at these liaison meetings. At these meetings, staff from the five participating agencies developed a collaborative style, working together to solve mutual and individual agency problems as they arose over the duration of the project. Through that process, the evaluation team has come to know a great deal more at an informal, qualitative level about the challenges of engaging in science-based prevention. The attending agency staff agree that this was an extremely useful process, lending somewhat to an action research approach to science-based prevention. The minutes from these meetings are provided in Appendix E.

Initially these meetings were held to identify shared objectives and provide trainings in program evaluation. The evaluation liaisons' functions were described as being responsible for identifying and fulfilling school policies regarding parental and child consent, responsibility for distribution and collection of evaluation measures to and from program educators, monitoring the experience of program educators with the evaluation and consulting with the statewide evaluation team on any difficulties that might arise, and responsibility for communicating summary information produced by the CRST to agencies and program educators. Typical meeting agendas discussed confidential vs. anonymous surveys in context of choosing between active and passive consent, development of a list of codes for our matching procedure, discussions of IRB policies, updates regarding program trainings and coordination of evaluation trainings, and discussions of sharing intermediate and outcome objectives for all three of the prevention curricula.

These initial meetings and a pilot of the programs assisted in refining the measures and determining the best steps for the *Replicating Science-based Substance Abuse Programs* demonstration project evaluation. Once the programs were in place, there was a growing confidence in the ability of agencies to assist in the evaluation and the focus of the agenda topics evolved into discussions of implementation issues. The CRST's role shifted from one of training and educating to one that provided technical assistance and support in implementation issues. However, the role of the liaison also switched to becoming the experts for many of the issues, as several of the liaisons were experienced program delivery staff and others were experienced supervisory staff. This mixture of supervisory, delivery, and evaluation specialists proved very effective for overcoming a variety of obstacles to implementation.

Some of the common themes in these liaison meetings involved issues with the Problem Based Prevention System (PBPS), recruiting families into the *Iowa Strengthening Families Program*, handling troublesome youth in class, establishing the best practices for getting youth to assent to taking the surveys, scheduling, fidelity, and difficulties from school and agency staff turnover. Three products resulted from these meetings. First, the agencies and the CRST worked together to create two documents that indicate how LST and PN curricula fit with the Standards of Health Curriculum in Rhode Island. These tools are invaluable for promoting the selected science-based programs into the school system (see Appendix F). A third product resulted from a focus group conducted in the spring of 2004, culminating in a report titled *Understanding the Process of Science-based Prevention: Implementer Perspectives: Report of Themes*

and Recommendations (see Appendix G). The findings from this meeting informed of common barriers and promising practices for building relationships with schools, training in science-based curricula, recruiting participants into family programs, and implementation of science-based programs.

Training in Curriculum Delivery

Agency staff who had been assigned to deliver the three curricula were trained by designated representatives of the developers during the spring of 2002. We conducted brief post-training surveys for each of the three trainings (Surveys are included in Appendix H). Table 5 provides information on a few of the items in that survey. For the most part respondents to our survey were those who were paid staff on this project, but there were others who also took the Iowa Strengthening Families training, primarily additional staff from the same agencies. Sample sizes are small and we will simply report some descriptive findings. The participants reported a moderate amount of previous experience with science-based curricula (40% to 60% had had some). The trainings were all rated relatively positively, although qualitative comments were more mixed for the Project Northland training. Ratings of confidence in one's ability to deliver the curriculum as designed, and in the curriculum's effectiveness for the particular target populations of local agencies, were a bit lower for the Life Skills Training curriculum.

Table 5. Educator Training Evaluation Ratings

Training Evaluation Item	Program Training Ratings		
	ISFP	Project Northland	Life Skills Training
Number of respondents	21.0	5.0	7.0
White (%)	71.4	100.0	71.4
Previous experience with science-based curricula (% yes)	40.0	60.0	42.9
Rating of the training: "How well did it work for you?" on a 5-point scale	4.2* "very well"	4.0** "very well"	3.8*** "very well"
Confidence in ability to deliver the program on a 5-point scale	4.3 "confident"	4.8 "very confident"	3.8 "confident"
Confidence in the curriculum's effectiveness for "your students/famiilies"	3.8 "confident"	3.8 "confident"	3.3 "moderately confident"

* Positive comments: "excellent presenters, thorough, walked us through all aspects of the program"

** Mixed comments: "needed more focus on logistics, timeline, specific tasks," "the training was clear and well presented"

*** Positive comments: "much information," "the trainer was very enthusiastic and helpful"

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Sustainability

Likelihood of Institutionalizing Science-based Programs

We conducted an informal survey of the staff who had delivered the prevention curricula in the project, asking about their views of the curricula and their perception of the likelihood that the curricula would continue to be delivered at the sites where the project was located. All PN schools indicated that they planned to continue the PN curriculum. One of the four LST schools was confident they would do so, and another was uncertain.

Reflections on Potential for Institutionalization

LST has substantially more sessions than PN in the initial year, and the booster sessions for LST are very repetitive of the first year's content. Classroom teachers and agency staff who were delivering the curricula appeared to find PN a more positive experience, especially in the 2nd and 3rd years. At the end of the program those prevention educators rated PN as more appropriate for their local conditions, and more likely to be locally effective.

A second aspect of sustainability concerns staffing. Using classroom teachers employed by the school (i.e. health education teachers) to deliver the curriculum (with appropriate training from the program developers) was associated with a higher rate of institutionalization.

ISFP was viewed as an excellent program, but is very expensive and "labor intensive."

Program Outcomes

Instrumentation

Six different instruments were assembled for measuring outcomes for the evaluation of this project and can be viewed in Appendix B along with their accompanying codebooks.

Youth Participant Questionnaires.

Two surveys containing six sections were created and used for pretest and posttest measures. The first five sections made up a "standard item set" developed to function as a core for our youth self-report outcome measures across programs. This item set included tracking items, demographic and substance use items, and major risk and protective scales. Section six was devoted to measure program specific outcomes. The questionnaires were designed with the use of Teleforms© software to facilitate data entry. Program educators administered these instruments at the first session of the classroom curricula (after participant assent was obtained) and again following the last session. The same administration process was followed in years two and three. Two additional surveys identical to the surveys described above (excluding the tracking questions) were utilized to measure responses from the 8th graders in the same schools in year one of the program. These measures were utilized to provide comparison group data and were only collected on one occasion. Codebooks were created to provide the source of the items or scales used, a brief description of the item or scale, values of the response set, the procedure for creating the scale, and the objectives sought.

Table 6 contains information on the scales utilized in the LST version, which includes the source, direction of scoring and scale psychometrics. Items in section 2, and scales in sections 3 through 5 were selected for their value in providing statewide planning data and for comparability with other accessible data. Measures were adapted from various sources such as the Monitoring the Future survey (MTF; Johnston, O'Malley & Bachman, 2000), Youth Tobacco Survey (The Office of Health Statistics, Rhode Island Department of Health), Communities That Care (CTC; Hawkins & Catalano), and the Life Skills Health Survey (LSHS; Institute for Prevention Research, Department of Public Health, Cornell University Medical College; Kenneth Griffin, Gilbert Botvin). Some of the scales were renamed in order to be consistent with the scoring direction, likewise, other scales were recoded in order for higher values to indicate higher levels of a certain skill or cognitive schema (e.g., attitude). Section six was devoted to measuring program specific objectives for the Life Skills Training curricula. Drug refusal skills were measured at two conceptual levels, saying no to offers of each drug and a variety of options (e.g., changing the subject) for saying no. These two scales were combined to measure an overall drug refusal skill. Because of the low instances of substance use and the associated risk factors for the majority of youth in the program at baseline, some scales required transformations. One transformation technique used was dichotomizing, which involves changing the distribution of data. For example: changing a 7-item response (i.e., 1 = never used drugs to 7 = 40 or more occasions) to a 2-item response (i.e., never used drugs vs. one to several occasions of use). Other transformations included using the natural logarithm and adding 1 to the means of a scale in place of the original mean or, to increase the means exponentially.

Table 7 contains the scale psychometrics for year 1 of the PN survey. The PN version was identical to the LST survey in the first 5 sections, however reflects the first year administration in the schools implementing PN. Section 6 contains scales specific to the Project Northland curricula. Scales were adapted from The Partnerships for Youth Health Student Survey (PN; Cheryl Perry, Division of Epidemiology, School of Public Health, University of Minnesota, Minneapolis; Williams et al., 1995) and the CTC survey (Hawkins & Catalano). Parent communication was measured with 4 items, however one

item was excluded to improve the alpha level. The Reasons Not to Use Alcohol items have been used in other research and provided reasonable alpha. The tables of scale psychometrics for the 8th grade survey is located in Appendix I.

Iowa Strengthening Families Questionnaires.

Two surveys were created (using Teleforms© software) for the participants in the ISFP. Participants completed the same survey for both pretest at the initial session and posttest at the end of the final session. The instruments and codebooks can be viewed in Appendix B. Parents and youth were measured on the same constructs; however, the number of items was reduced for the youth version. Similar to the Youth Participant Questionnaires described above, respondents completed a unique identifier code that was used to match participant responses from pretest to posttest.

Table 8 contains the scale properties for the initial 7 sessions of the ISFP. Measures were adapted from various sources such as: Project Family researchers (Spoth, Redmond, Haggerty and Ward, 1995), Iowa Youth and Families Project (Conger, 1989), Communities That Care (Hawkins & Catalano), and the Youth Tobacco Survey (The Office of Health Statistics, Rhode Island Department of Health). The scale alphas ranged from .669 to .938, which indicates a reasonable reliability for the measure overall. One scale, the Parental Expectations of Non-use required an exponential transformation.

Table 6 Measures and Scale Psychometrics for Year 1 - LST program

Section and Scale	Source	Range	Scoring direction	Number of items	N	MIN	MAX	MEAN	STD	Alpha	Transformation type
2: Age of initiation alcohol	MTF	1= never 2= 14 years or older… 8= 8 years old or younger		1	668	1	7	1.3	0.996	N/A	dichotomized 0= never 1= initiated
2: Age of initiation tobacco	YTS	1= never 2= 14 years or older… 8= 8 years old or younger		1	670	1	7	1.1	0.726	N/A	dichotomized 0= never 1= initiated
2: Age of initiation marijuana	YTS	1= never 2= 14 years or older… 8= 8 years old or younger		1	687	1	7	1.1	0.648	N/A	dichotomized 0= never 1= initiated
2: 30 day alcohol prevalence	MTF	1= 0 occasions 7= 40 or more occasions		1	676	1	6	1.1	0.369	N/A	dichotomized 0= never 1= one or more occasion
2: 30 day tobacco prevalance	YTS	1= 0 days 7= All 30 days		1	678	1	7	1.0	0.343	N/A	dichotomized 0= never 1= one or more occasion
2: 30 day marijuana prevalance	YTS	1= 0 occasions 7= 40 or more occasions		1	675	1	7	1.0	0.292	N/A	dichotomized 0= never 1= one or more occasion
2: Problem drinking	MTF	1= none 6= 10 or more times		2	636	0	1	0.0	0.142	N/A	dichotomized 0= never 1= one or more occasion
3: Peer disapproval scale	MTF	1= Approve 3= Disapprove	Higher scores = more peer disapproval	4	688	1	3	2.9	0.389	0.94	Exponential
3: Perceived risk scale	MTF	1= No risk 3= Great risk	Higher scores = greater perceived risk	5	638	1	3	2.7	0.448	0.86	Exponential
3: Favorable attitudes toward drug use	CTC	1= Very wrong 4= Not wrong at all	Higher scores = more favorable attitudes toward substance use	4	686	1	4	1.2	0.478	0.88	Natural log plus 1
4: Family attachment scale	CTC	1= NO! 4=YES!	Higher scores = stronger family attachment	4	675	1	4	3.2	0.741	0.81	
4: Parental attitudes toward drug use	CTC	1= Not wrong at all 4= Very wrong	Higher scores = greater parental disapproval toward substance use	3	680	1	4	1.1	0.318	0.82	Natural log plus 1
5: Drug use intentions	LSHS	1= Definitely not 5= Definitely will	Higher scores = greater intentions to use within the next year	5	681	1	5	1.2	0.502	0.89	Natural log plus 1
5: Peer normative beliefs	LSHS	1= None 5= All or almost all	Higher scores = perception that more peers use drugs	5	681	1	5	2.0	0.872	0.93	
6: Drug refusal skills alternate scale	LSHS	1= Definitely would not 5= Definitely would	Higher scores = more or better refusal skills	10	661	1	5	3.9	1.194	0.91	
6: Drug attitudes - pro drug composite scale	LSHS	1= Strongly disagree 5= Strongly agree	Higher scores = positive attitude toward substance use	8	668	1	5	1.3	0.632	0.95	Natural log plus 1
6: Social skills scale	LSHS	1= Strongly disagree 4= Strongly agree	Higher scores = better social skills	5	675	0	10	2.5	2.123	0.78	
6: Stress management skills	CSAP	1= Strongly dsagree 4= Strongly agree	Higher scores = better stress management skills	4	660	0	10	3.2	2.255	0.85	

Source: MTF Monitoring the Future; YTS Youth Tobacco Survey; CTC Communities That Care; LSHS Life Skills Health Survey

Table 7 Measures and Scale Psychometrics for Year 1 - PN program

Section and Scale	Source	Range	Scoring Direction	Number of items	N	Min	Max	Mean	STD	Alpha	Transformation type
2: Age of initiation alcohol	MTF	1= never 2= 14 years or older... 8= 8 years old or younger		1	717	1	7	1.3	0.958	N/A	dichotomized 0= never 1= initiated
2: Age of initiation tobacco	YTS	1= never 2= 14 years or older... 8= 8 years old or younger		1	720	1	7	1.1	0.561	N/A	dichotomized 0= never 1= initiated
2: Age of initiation marijuana	YTS	1= never 2= 14 years or older... 8= 8 years old or younger		1	719	1	7	1.0	0.423	N/A	dichotomized 0= never 1= initiated
2: 30 day alcohol prevalence	MTF	1= 0 occasions 7= 40 or more occasions		1	714	1	7	1.0	0.301	N/A	dichotomized 0= never 1= one or more occasion
2: 30 day tobacco prevalence	YTS	1= 0 days 7= All 30 days		1	720	1	4	1.0	0.158	N/A	dichotomized 0= never 1= one or more occasion
2: 30 day marijuana prevalence	YTS	1= 0 occasions 7= 40 or more occasions		1	714	1	2	1	0.037	N/A	dichotomized 0= never 1= one or more occasion
2: Problem drinking	MTF	1= none 6= 10 or more times		2	698	0	1	0.0	0.084	N/A	dichotomized 0= never 1= one or more occasion
3: Peer disapproval scale	MTF	1 = Approve 3 = Disapprove	Higher scores = more peer disapproval	4	725	1	3	2.9	0.382	0.94	Exponential
3: Perceived risk scale	MTF	1 = No risk 3 = Great risk	Higher scores = greater perceived risk	5	680	1	3	2.7	0.375	0.79	Exponential
3: Favorable attitudes toward drug use	CTC	1 = Very wrong 4 = Not wrong at all	Higher scores = more favorable attitudes toward substance use	4	718	1	4	1.2	0.396	0.86	Natural log plus 1
4: Family attachment scale	CTC	1 = NO! 4 =YES!	Higher scores = stronger family attachment	4	713	1	4	3.3	0.656	0.79	
4: Parental attitudes toward drug use	CTC	1 = Not wrong at all 4 = Very wrong	Higher scores = greater parental disapproval toward substance use	3	721	1	4	1.1	0.299	0.89	Natural log plus 1
5: Drug use intentions	LSHS	1 = Definitely not 5 = Definitely will	Higher scores = greater intentions to use within the next year	5	718	1	5	1.1	0.353	0.80	Natural log plus 1
5: Peer normative beliefs	LSHS	1 = None 5 = All or almost all	Higher scores = perception that more peers use drugs	5	719	1	5	2.0	0.803	0.92	
6: Parent communication	PN	1 = False 2 = True	Higher scores = better parent-child communication	3	720	1	2	1.9	0.285	0.67	Exponential
6: Reasons Not to Use Alcohol	PN	1 = Not too important for me 5 = Very important for me	Higher scores = more importance to reasons and consequences for not using alcohol	10	697	1	5	4.3	0.838	0.89	Exponential
6: Interaction with antisocial peers	PN	1 = None of my friends 5 = 4 of my friends	Higher scores = more association with negative peers	6	696	1	5	1.1	0.334	0.76	Natural log plus 1
6: Rules and consequences against drinking	PN	1 = False 2 = True	Higher scores = more family rules	1	716	1	3	1.4	0.775	N/A	

Source: MTF Monitoring the Future; YTS Youth Tobacco Survey; CTC Communities That Care; LSHS Life Skills Health Survey; Partnerships for Youth Health Student Survey

Table 8 Measures and Scale Psychometrics for First 7 Sessions ISFP

	Section and Scale	Source	Range	Scoring direction	Number of items	N	MIN	MAX	MEAN	STD	Alpha	Transformation type
Parent/Caregiver	Parental limit setting and monitoring	Spoth	1 = Always 7 = Never	Higher scores correspond to positive parenting skills	13	145	3.4	6.5	5.4	0.623	0.73	
	Family nurtruing and protective qualities	Spoth	1 = Always 7 = Never	Higher scores correspond to positive parenting skills	7	145	2.8	6.9	5.3	0.852	0.80	
	Parent-child communication	Spoth	1 = Strongly disagree 5 = Strongly agree	Higher scores correspond to positive parenting skills	5	142	2.2	5	4.2	0.618	0.82	
	Parent-child involvement	Spoth	1 = Not true 4 = Always or almost always	Higher scores correspond to positive parenting skills	6	142	2.2	4	3.2	0.457	0.74	
	Parental expectations of non-use	Spoth	1 = Strongly disagree 5 = Strongly agree	Higher scores correspond to positive parenting skills	3	140	1	5	4.4	0.933	0.87	Exponential
Youth	Parental limit setting and monitoring	CTC	1 = NO! 4 = YES!	Higher scores correspond to higher preceived parenting skills	6	96	2.3	4	3.5	0.408	0.67	
	Family nurtruing and protective qualities	Spoth	1 = Always 7 = Never	Higher scores correspond to higher preceived parenting skills	7	98	2	7	5.5	1.175	0.81	
	Parent-child communication	FFS	1 = Never 7 = Always	Higher scores correspond to higher preceived parenting skills	8	94	1	7	4.2	1.441	0.87	
	Parent-child involvement	Spoth	1 Not true 4 = Always or almost always true	Higher scores correspond to higher preceived parenting skills	6	94	1	4	3.1	0.685	0.89	
	Parental expectations of non-use	YTS	1 = Strongly disagree 4 = Strongly agree	Higher scores correspond to higher preceived parenting skills	3	92	4	4	3.7	0.673	0.94	Exponential

Source: Spoth Project Family; Iowa Youth and Families; CTC Communities That Care; FFS Family Functioning Scale

Major Questions Addressed: Outcomes on Intermediate Objectives in Year 1

Intermediate PN Objectives for Year 1

Survey data from the pre-test and post-test in Year 1 were used to examine the four intermediate objectives established for Project Northland. As Table 9 indicates, the combined results for the four sites yielded extremely small changes and none of the individual sites receiving PN achieved any of these objectives.

Intermediate LST Objectives for Year 1

Table 9 also reports the findings for the LST intermediate objectives in Year 1. One of the five intermediate objectives was achieved when data from the fours sites were combined: There was a 19.5% increase in self-rated social skills from the pre-test to the post-test. Three of the four sites were very successful on this objective. None of the other LST objectives was achieved in Year 1 for the combined sites, although one site did achieve a 24% increase in stress management skills.

Intermediate ISFP Objectives for Year 1

The sample sizes for individual sites were too low to make comparisons for each site, so only the combined data for all eight sites are reported in Table 9. When we examined our data for both parents/caregivers and youth, none of the five objectives was achieved. The most success was for Family Nurturing, which achieved a 6.2% increase in parent ratings (the objective called for 10%). One anomalous finding was the contrast between parents' report of a 6% increase in Parental Expectations for Non-use, while youth reported a 12% decrease.

Major Questions Addressed: Outcomes on Intermediate Objectives Over Three Years

Eighth Grade Treatment Group vs. Eighth Grade Comparison Group on Intermediate Objectives

Shared Intermediate Objectives

Eighth graders who participated for the three years of the two classroom programs were compared to "untreated" eighth graders who were surveyed in the spring of the year the programs began (2002). For the seven scales measuring intermediate outcomes that were administered to both the LST and the PN sites, we examined the results for all of the participants with a MANOVA. The results are summarized in Table 10. The F-test for the MANOVA was significant, indicating that the combination of the scales significantly differentiated between the treatment group (eighth graders who had been in the program for three years) and the comparison group (eighth graders who had completed the survey in the year the program began, and did not receive the program). Follow-up analyses indicated that in all cases the scale scores showed better results for the treated group, and in all but one case these differences were highly significant ($p<.001$). The largest differences were for Favorable Attitudes toward Drug Use (the treatment group had 14.5% lower favorable attitudes) and Drug Use Intentions (the treatment group had 16.4% lower intentions to use drugs). The only non-significant difference was for the Family Attachment Scale, a variable only peripherally related to the two in-school curricula.

Table 9 PERCENT CHANGES ON INTERMEDIATE OBJECTIVES IN YEAR ONE

Objectives	Positive=	Site 1	Site 2	Site 3	Site 4	Weighted Combination	Met Objective
Project Northland							
Favorable attitude toward alcohol use	10% decrease	1.20%	-2.80%	0.70%	-0.20%	**-0.23%**	
Involvement with antisocial peers	10% decrease	8.00%	1.90%	1.00%	-4.20%	**1.19%**	
Parent communication re alcohol	25% increase	-0.50%	1.60%	1.60%	0.50%	**0.76%**	
Rules and consequences re drinking	10% increase	-1.10%	0.00%	0.50%	0.50%	**-0.02%**	
Life Skills Training							
Social Skills	20% increase	26.00%	3.40%	28.10%	59.60%	**19.50%**	**yes**
Drug Refusal Skills	20% increase	9.90%	1.00%	5.40%	-6.40%	**5.44%**	
Stress Management Skills	20% increase	-1.90%	-17.40%	-8.10%	24.20%	**-7.93%**	
Favorable Attitudes toward Drugs	20% decrease	-4.00%	2.30%	-4.70%	-8.60%	**-2.09%**	
Perceived Peer Use	25% decrease	7.50%	2.10%	7.10%	1.50%	**5.40%**	
Iowa Strengthening Families Program							
Parent/Caregiver							
Parental Limit Setting	20% increase					**1.60%**	
Family Nurturing & Protective	10% increase					**6.20%**	**~**
Parent/child Communication	30% increase					**1.90%**	
Positive Parent/child Involvement	20% increase					**3.30%**	
Parental Expectations for Non-use	10% increase					**5.70%**	
Youth							
Parental Limit Setting	20% increase					**3.40%**	
Family Nurturing and Protective	10% increase					**2.50%**	
Parent/child Communication	30% increase					**7.70%**	
Positive Parent-child Involvement	20% increase					**3.30%**	
Parental Expectations of Non-use	10% increase					**-12.10%**	

Table 10. Comparisons of Eighth Grade Students (Comparison Group vs. Treatment Group) Shared Scales						
Scale	Range	Best Possible Score	Comparison Group	Treatment Group	Difference	*p*-value
Peer disapproval	1-3	3	2.7	2.8	3%	.001
Perceived risk	1-3	3	2.6	2.7	2%	.001
Favorable attitudes toward drug use	1-4	1	1.8	1.5	-15%	.001
Family attachment	1-4	4	2.9	2.9	0.3%	.424
Parental attitudes toward drug use	1-4	4	3.7	3.8	3%	.001
Drug use intentions	1-5	1	1.7	1.4	-16%	.001
Peer normative beliefs	1-5	1	2.5	2.3	-8%	.001

Non-shared Intermediate Objectives

For measures of intermediate objectives that were non-shared (that is, measures based on items that were only completed by students receiving one or the other program), we examined the amount and significance of the difference between the two groups. Table 11 provides these results, which are summarized below.

Project Northland only

The F-test for the MANOVA summary index is significant, indicating that there is evidence for group differences on a linear combination of the dependent variables. In other words, when all of the intermediate non-shared intermediate outcomes are looked at together there is a statistically significant difference between the treatment group and the comparison group. The multivariate effect size, or eta-squared (1- Wilks' Lambda) is small to moderate (.06). The F-tests for the follow-up ANOVAs on the dependent variables are all significant ($p<.01$) as well, with mostly small effect sizes. Mean comparisons indicate that the treatment group significantly outperformed the comparison group for each non-shared intermediate objective. The magnitudes of the differences are relatively small, ranging from an 8% higher negative attitude toward alcohol use for the treatment group, to 7% higher perceived quality of parent communication, to 6% lower reported interaction with negative peers and 6% higher perception that parents enforced rules and had consequences for ATOD use.

Life Skills Training only

The F-test for the MANOVA summary index is significant. This indicates that the treatment and the comparison group differ on a linear combination of the dependent variables. As for the PN comparison, when all of the non-shared intermediate outcomes are looked at together, the treatment group did significantly better than the comparison group. The multivariate effect size, or eta-squared (1- Wilks' Lambda) is small to moderate (.09). Of the five F-tests for the follow-up ANOVAs, three are significant. The treatment group had 8% higher drug refusal skills ($p=.000$), 18% lower pro-drug attitudes ($p<.000$), and 6% lower perceived peer norms for ATOD use ($p=.000$). Effect sizes are in the small to moderate range. The differences for social skills and stress management were not significant.

Table 11. Comparisons of Eighth Grade Students (Comparison Group vs. Treatment Group) Non-shared Scales					
Items	Range	Comparison Group	Treatment Group	% Difference	*p*-value
Project Northland Only					
Negative attitude toward alcohol use	1-5	3.5	3.8	8%	.001
Interaction with antisocial peers	1-5	1.4	1.3	-6%	.003
Parent communication	1-2	1.7	1.8	7%	.001
Rules and consequences	1-2	1.8	1.9	6%	.001
Life Skills Training Only					
Social Skills Scale	0-10	7.9	8.0	1%	.142
Drug Refusal Scale	1-5	3.9	4.2	8%	.001
Stress Management Scale	0-10	7.9	7.0	-2%	.419
Drug Attitudes: Pro-drug	1-5	1.7	1.4	-18%	.001
Peer Normative Beliefs	1-5	2.4	2.3	-6%	.001

Time 1 to Time 6 Comparisons (PN Treatment Group vs. LST Treatment Group) on Selected Intermediate objectives

We ran four ANCOVAs to test whether the programs had a differential effect on two intermediate outcomes: Family Attachment (FAS) and Parental Attitudes Towards Drug Use (PATDU). Family attachment and perceived parental attitudes toward drug use can conceivably improve over time. The other scales analyzed in the 8th to 8th grade comparisons above are confounded with normal developmental changes and therefore were not analyzed. The covariate in these analyses was the intermediate outcome at time 1. The ANCOVAs indicate there were no differential program effects on an overall basis. Also there were no significant interaction effects by gender or by SES. The only marginally significant result (p=.04) is the two genders differed on family attachment with females reporting somewhat lower attachment.

Graphic displays in Figures 4, 5, 6, and 7 provide more detail on how Family Attachment and Parental Disapproval of Drug Use (as reported by the youth) changed over the three years of the intervention. Figures 4 and 5 both display consistent declines over time in Family Attachment for all of the subgroups across programs, as would be expected for early adolescents. There were no differences across the programs in the patterns over time. The two noticeable aspects of the pattern beyond the general decline are somewhat lower attachment for non-White participants and females (the latter was significant in the previously reported ANCOVA results). Figure 6 suggests that initial positive program effects on Parental Disapproval were overcome by normal developmental decline during early adolescence. For males there appeared to be an initial difference between the programs, with LST males reporting lower Parent Disapproval than PN males, followed by a greater increase in disapproval for the LST males. However, this pattern was not statistically significant. Figure 7 shows a consistent decline over time for both White and non-White groups after the initial sessions of the curricula and hints at White youth perceiving more parental disapproval than their non-White peers over the three years. However, these differences were not statistically significant. There was a large increase in perceived disapproval after the initial 15 sessions of LST for non-White participants.

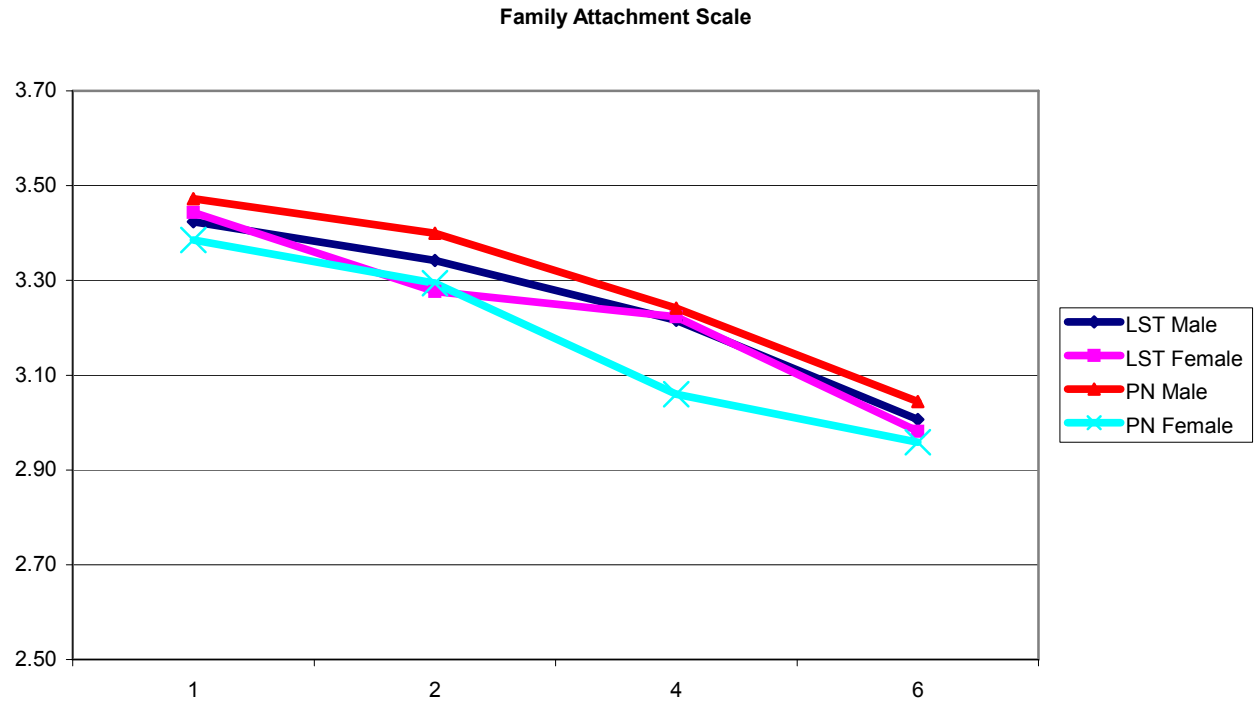

Figure 4. Family Attachment by Gender

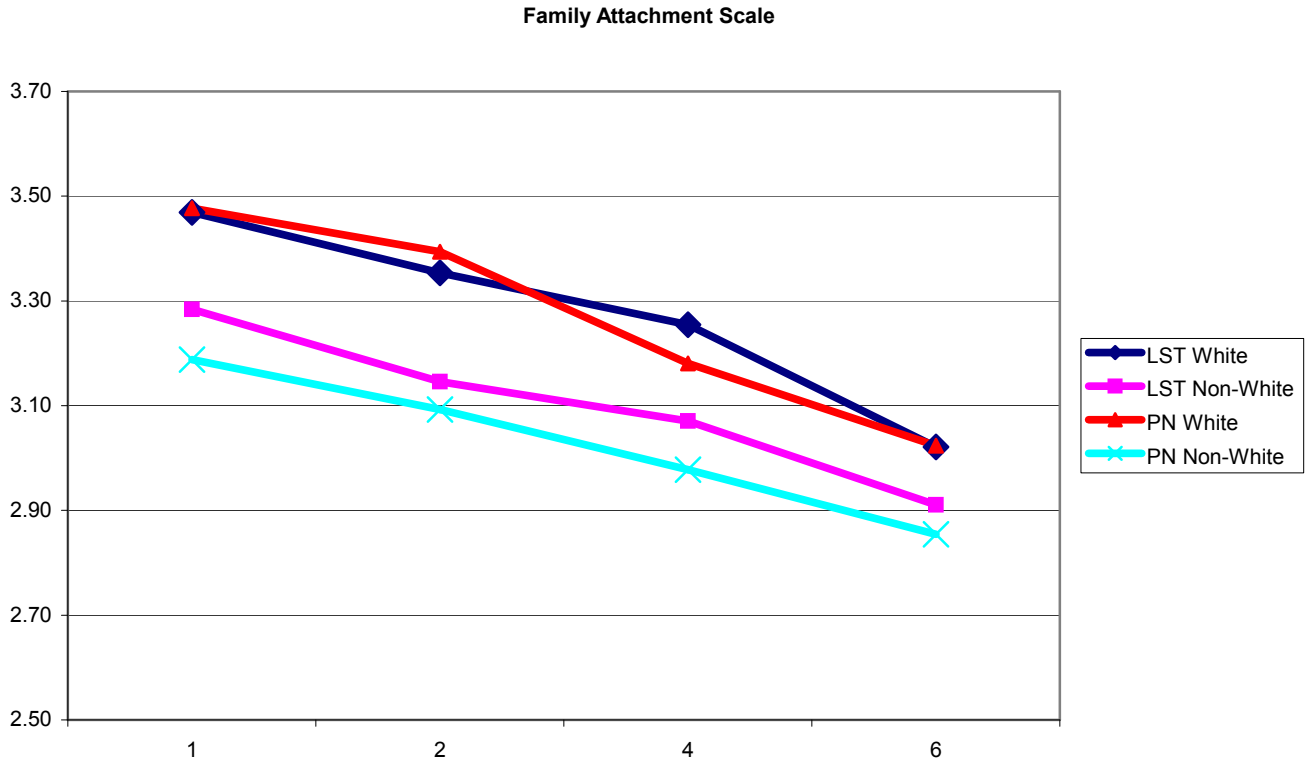

Figure 5. Family Attachment by Race

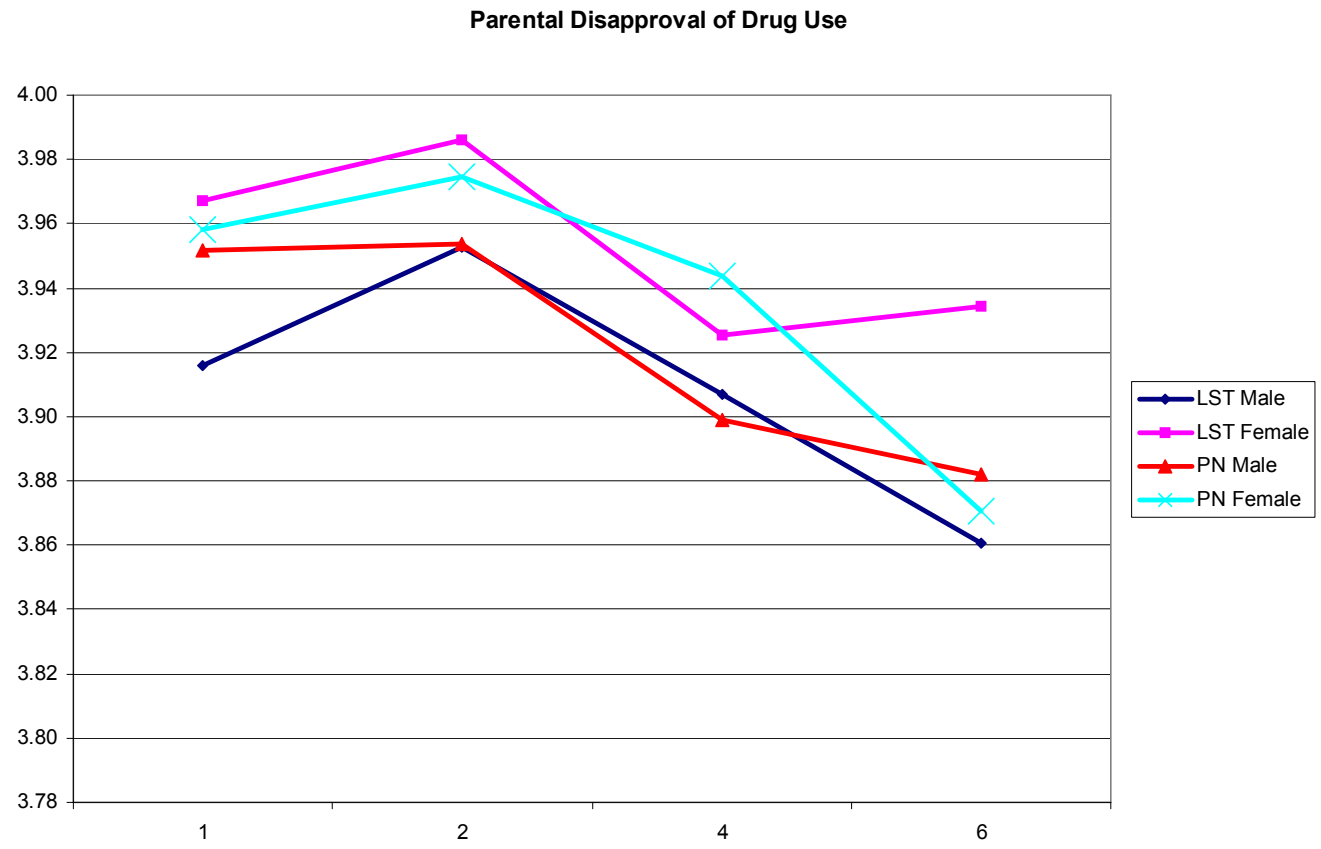

Figure 6. Parental Disapproval of Drug Use by Gender

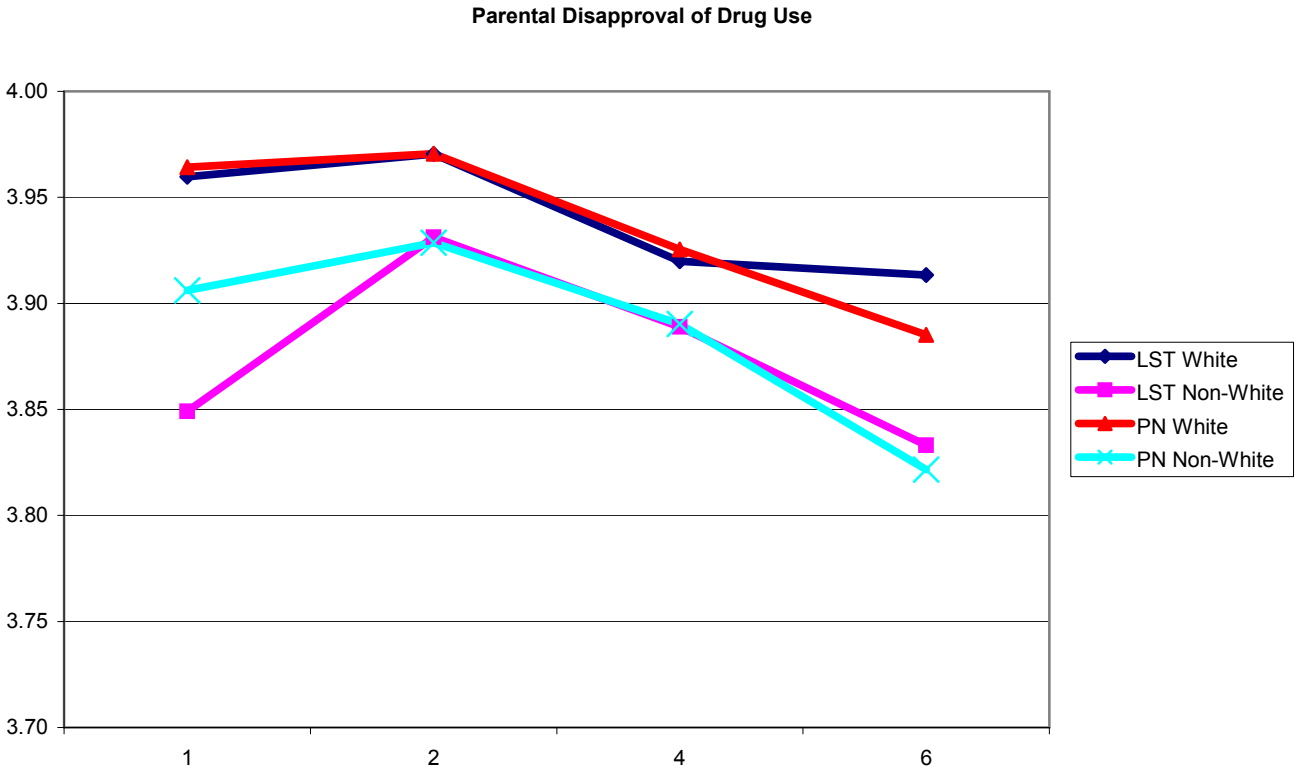

Figure 7. Parental Disapproval of Drug Use by Race

Intermediate ISFP Objectives: Statistical Comparisons

We ran paired samples t tests to determine whether there were significant changes in the intermediate outcomes for the ISFP project. For the parents, all five intermediate outcomes were significantly ($p<.01$) higher at time 2, compared to time 1 (see Tables 12 and 13). These results suggest that the program was very effective for the parents.

Table 12. Mean ratings by parents of intermediate variables in the ISFP program

		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	T1 Family Nurturing & Protective Qualities	5.3	103	.823	.081
	T2 Family Nurturing & Protective Qualities	5.7	103	.632	.062
Pair 2	T1 Parent-Child Communication	4.2	102	.604	.060
	T2 Parent-Child Communication	4.3	102	.471	.047
Pair 3	T1 Parent-Child Involvement	3.2	102	.450	.045
	T2 Parent-Child Involvement	3.4	102	.412	.041
Pair 4	T1 Parental Expectations of Non-use	4.4	101	.767	.076
	T2 Parental Expectations of Non-use	4.7	101	.471	.047
Pair 5	T1 Parental Limit Setting & Monitoring	5.5	104	.618	.061
	T2 Parental Limit Setting & Monitoring	5.6	104	.542	.053

Table 13. T-tests for pre-test to post-test changes on parent-rated ISFP intermediate variables

	Mean Difference	Std. Deviation	*t*	*df*	Sig (2-tailed)
T1 Family Nurturing & Protective Qualities T2 Family Nurturing & Protective Qualities	-.360	.602	-6.06	102	.000
T1 Parent-Child Communication T2 Parent-Child Communication	-.152	.538	-2.86	101	.005
T1 Parent-Child Involvement T2 Parent-Child Involvement	-.168	.357	-4.77	101	.000
T1 Parental Expectations of Non-use T2 Parental Expectations of Non-use	-.337	.694	-4.88	100	.000
T1 Parental Limit Setting & Monitoring T2 Parental Limit Setting & Monitoring	-.160	.540	-3.02	103	.003

For the youth, however, only one difference was significant ($p=.021$) (see Tables 14 and 15). The youth at time 2 rated their parents higher than they rated them at time 1 for the Limit Setting and Monitoring variable. In the case of youth-rated parental expectations of non-use, the youth actually seemed to be indicating a decrease in expectations of non-use (although this was not significant), contrary to the parents.

Table 14. Mean ratings by youth of intermediate variables in the ISFP program					
		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	T1 Family Nurturing & Protective Qualities	5.5	98	1.175	.119
	T2 Family Nurturing & Protective Qualities	5.5	98	1.175	.119
Pair 2	T1 Parent-Child Communication	4.2	94	1.441	.149
	T2 Parent-Child Communication	4.4	94	1.579	.163
Pair 3	T1 Parent-Child Involvement	3.1	94	.685	.071
	T2 Parent-Child Involvement	3.2	94	.735	.076
Pair 4	T1 Parental Expectations of Non-use	3.7	92	.673	.070
	T2 Parental Expectations of Non-use	3.5	92	.959	.100
Pair 5	T1 Parental Limit Setting & Monitoring	3.5	96	.408	.042
	T2 Parental Limit Setting & Monitoring	3.6	96	.405	.041

Table 15. T-tests for pre-test to post-test changes on youth-rated ISFP intermediate variables					
	Mean Difference	Std. Deviation	*t*	*df*	Sig (2-tailed)
T1 Family Nurturing & Protective Qualities T2 Family Nurturing & Protective Qualities	.000				*
T1 Parent-Child Communication T2 Parent-Child Communication	-.171	1.219	-1.36	93	.177
T1 Parent-Child Involvement T2 Parent-Child Involvement	-.083	.538	-1.50	93	.138
T1 Parental Expectations of Non-use T2 Parental Expectations of Non-use	.201	1.083	1.78	91	.078
T1 Parental Limit Setting & Monitoring T2 Parental Limit Setting & Monitoring	-.089	.370	-2.35	95	.021

*There was no difference in scores between T1 and T2. Therefore, a significance level could not be calculated.

Major Questions Addressed: Outcomes on Ultimate Objectives Over Three Years

Eighth Grade Treatment Group vs. Eighth Grade Comparison Group

Eighth graders who participated for the three years of the two classroom programs were compared to "untreated" eighth graders who were surveyed in the spring of the year the programs began (2002). For measures of outcome objectives (i.e., 30-day prevalence of use, initiation of use during 7th and 8th grades, and problem drinking), we examined the amount and significance of the difference between the two groups. We used logistic regressions to compare the treatment and comparison groups, and it is important to note that because we calculated separate significance tests for each dependent variable we increased the risk of family-wise error. However, we believe the consistency in the pattern of findings supports their credibility. We have selected 30-day prevalence of alcohol use and initiation of alcohol use as the best illustrations of program effects. We have also selected three demographic variables, eligibility for subsidized lunch (which reflects socioeconomic status), White non-Hispanic/Latino vs. non-White and Hispanic/Latino, and gender, as control factors to examine whether the programs had differential effects on demographic sub-groups.

Use of Alcohol in the Past 30 Days

The effects of receiving a curriculum on 30-day prevalence of alcohol use were statistically significant ($p<.001$) when PN and LST schools were combined (see Table 16). Students who received a prevention curriculum were about 46% less likely to report using alcohol in the past 30 days than an untreated comparison group. There were no overall statistical differences between the effects of the two programs.

Table 16. Comparisons of Eighth Grade Students (Treatment Group vs. Comparison Group) on 30-Day Alcohol Use

Program	Treatment	Control	% Difference
LST	11%	23%	-52.2%
PN	13%	21%	-38.1%
Combined	12%	22%	-45.5%

When the effects of the two programs were looked at separately for white students and non-white students, there were differences in program effects (see Table 17). The two programs were significantly different in their effects on white students ($p<.05$), with LST having greater effects than PN on 30-day prevalence of alcohol use for white students. There were no significant differences between the programs in effects on non-whites.

Table 17. Comparisons of 8th Grade Students (Treatment Group versus Comparison Group) on 30-Day Alcohol Use, Controlling for Race

Program	Race	Treatment	Comparison	% Difference
LST	White	9%	22%	-59.1%
	Non-White	14%	28%	-50.0%
PN	White	11%	17%	-35.3%
	Non-White	18%	30%	-40.0%

When the effects of the two programs were looked at separately for students who qualified for subsidized lunches and those who did not, there were differences in program effects (see Table 18). The two programs were marginally different ($p<.06$) in their effects on full-pay students, with LST having greater effects than PN on 30-day prevalence of alcohol use for full-pay students. There were no significant differences between the programs in effects on students receiving lunch subsidies.

Table 18. Comparisons of Eighth Grade Students (Treatment Group versus Comparison Group) on 30-Day Alcohol Use, Controlling for S.E.S.

Program	Race	Treatment	Comparison	% Difference
LST	Full-pay Lunch	8%	21%	-61.9%
	Subsidized Lunch	15%	25%	-40.0%
PN	Full-pay Lunch	13%	20%	-35.0%
	Subsidized Lunch	14%	25%	-44.0%

When the effects of the two programs were looked at separately for male and female students, there were differences in program effects (see Table 19). The two programs were marginally different ($p<.06$) in their effects on males, with LST having greater effects than PN on 30-day prevalence of alcohol use for male students. There were no significant differences between the programs in effects on females.

Table 19. Comparisons of Eighth Grade Students (Treatment Group versus Comparison Group) on 30-Day Alcohol Use, Controlling for Gender				
Program	Gender	Treatment	Comparison	% Difference
LST	Male	11%	26%	-59%
	Female	12%	20%	-41%
PN	Male	13%	20%	-33%
	Female	13%	21%	-38%

Initiation of Alcohol Use During Seventh and Eighth Grade

The effects of receiving a curriculum on initiation of alcohol use were statistically significant ($p<.001$) when PN and LST schools were combined (see Table 20). Students who received a prevention curriculum were 34% less likely to report using alcohol in the past 30 days than the untreated comparison group. There was an overall statistically significant difference between the effects of the two programs, with PN substantially more likely to produce effects on initiation of use.

Table 20. Comparisons of Eighth Grade Students (Treatment Group versus Comparison Group) on Initiation of Alcohol Use			
Program	Treatment	Control	% Difference
LST	14%	14%	0%
PN	19%	33%	-42.4%
Combined	17%	25%	-34.0%

When the effects of the two programs on initiation of alcohol use were looked at separately for white students and non-white students, there were differences in program effects (see Table 21). The two programs were significantly different in their effects on non-white students ($p<.02$), with PN having greater effects than LST on initiation of alcohol use for non-white students. There were no significant differences between the programs in effects on white students.

Table 21. Comparisons of Eighth Grade Students (Treatment Group versus Comparison Group) on Initiation of Alcohol Use, Controlling for Race				
Program	Race	Treatment	Comparison	% Difference
LST	White	10%	13%	-23.1%
	Non-White	20%	23%	-13.0%
PN	White	19%	31%	-38.7%
	Non-White	17%	37%	-54.0%

When the effects of the two programs were looked at separately for students who qualified for subsidized lunches and those who did not, there were differences in program effects on initiation of alcohol use (see Table 22). The two programs were significantly different ($p<.003$) in their effects on subsidized students, with PN associated with substantial reductions in initiation of alcohol use for subsidized (lower S.E.S.) students, while LST was associated with somewhat higher initiation of use. There were no significant differences between the programs in effects on students who paid full price for lunch.

Table 22. Comparisons of Eighth Grade Students (Treatment Group versus Comparison Group) on Initiation of Alcohol Use, Controlling for S.E.S.				
Program	Race	Treatment	Comparison	% Difference
LST	Full-pay Lunch	10%	13%	-23.1%
	Subsidized Lunch	19%	16%	18.7%
PN	Full-pay Lunch	18%	31%	-41.9%
	Subsidized Lunch	22%	39%	-43.6%

When the effects of the two programs on initiation of alcohol use were looked at separately for male and female students, there were differences in program effects (see Table 23). The two programs were significantly different in their effects on male students ($p<.05$), with PN having greater effects than LST on initiation of alcohol use for males. There was also a significant difference in program effects on female students ($p=.001$) with PN associated with a substantial positive program effect whereas LST was associated with an anomalous finding of higher initiation by the treatment group.

Table 23. Comparisons of Eighth Grade Students (Treatment Group versus Comparison Group) on Initiation of Alcohol Use, Controlling for Gender				
Program	Gender	Treatment	Comparison	% Difference
LST	Male	14%	17%	-13%
	Female	15%	12%	22%
PN	Male	18%	32%	-45%
	Female	19%	33%	-43%

Problem drinking

The programs did have a significant effect ($p<.001$) on problem drinking (see Table 24). Eighth grade youth in the comparison group had a 10.9% rate of binge drinking, while the eighth grade youth in the treatment group had a 6.5% rate. This represents a 40% decrease. Analyses that compared the overall effects of the two programs and the effects of the two programs on different demographic groups did not reveal any significant ($p>.05$) differential effects.

Table 24. Comparisons of Eighth Grade Students (Treatment Group versus Comparison Group) on Problem Drinking			
Program	Treatment	Control	% Difference
LST	6.0%	12.2%	-51%
PN	7.0%	10.0%	-31%
Combined	6.5%	10.9%	-40%

Additive effects of ISFP participation on alcohol use (30-day prevalence)

In order to address the question of the value of adding the ISFP program to the in-school curricula, we used self-report from youth participants in the classroom interventions to identify those who had also participated with their family members in the ISFP program. We examined the pattern of change in alcohol use over the three years of the project for our treatment group, comparing those who had or had

not received ISFP along with either PN or LST. Logistic regression analyses indicated that the ISFP variable (0 = did not participate, 1 = did participate) was not a significant (p>.05) predictor of alcohol initiation or 30-day alcohol prevalence. This result is not surprising, however, given the small number of students who participated in ISFP (n=98) compared to the number of students who did not participate in the program. Of the 709 youth that we were able to track across the entire three years of the program, only 21 youth received both LST and ISFP, and only 51 received both PN and ISFP.

In addition we examined these patterns graphically. We included the initial pre-test (time 1) and the three post-tests (times 2, 4, and 6). Figure 8 presents these findings. The treatment cohort is separated into four groups: LST + ISFP, LST without ISFP, PN + ISFP, and PN without ISFP. The graphs indicate that the youth who received LST or PN with ISFP had moderately better results than those youth who only received the LST or PN program. However, these results were not significant (p>.05). Despite the lack of a statistically significant difference between the groups, the pattern for the LST + ISFP group deserves comment. At the point of the initial pre-test this group was by far the most likely to have used alcohol in the past month (15% reported doing so), but by the final post-test in the third year (time 6) they reported the least use (5%). The other three groups all reported modest increases in alcohol use. The PN + ISFP group initially reported the lowest amount of use and ended with relatively low use as well. It is possible that selection factors played a role: at LST schools, higher risk families may have been more likely to participate in ISFP, while in PN schools it may have been the low risk families who were more likely to participate.

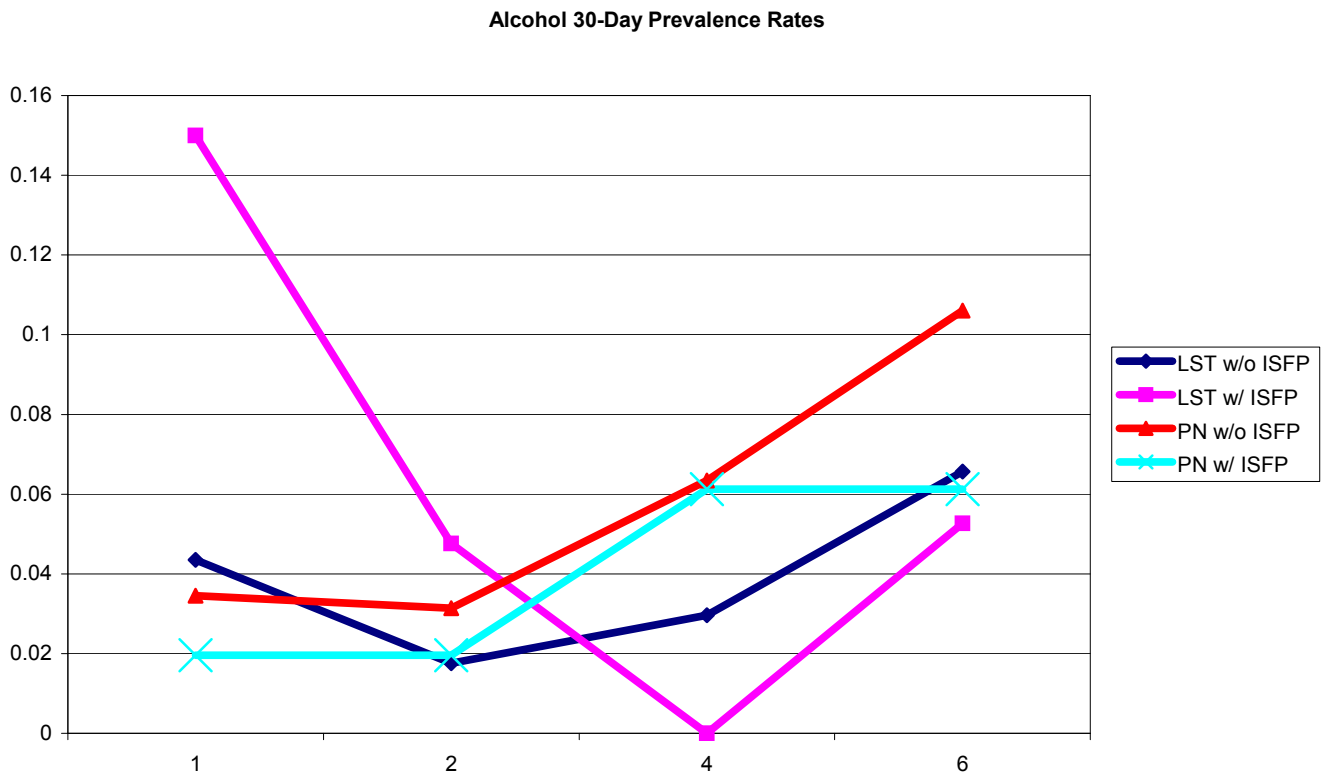

Figure 8 Comparing youth who received ISFP to those who did not

SALT Survey Results for 30-Day Prevalence of Alcohol Use

Our comparison of two groups of eighth graders, those who had received the programs and another group from the same schools who had not, showed very clear and positive effects for the programs. However, it was possible that the comparison group of eighth graders, surveyed in the spring of 2003, appeared to have a higher prevalence of alcohol use than our treatment group, surveyed in the spring of 2005, because eighth graders across the state had a higher prevalence in 2003 than in 2005. In order to check that possibility we examined SALT student survey data on 30-day prevalence of alcohol use by eighth graders for four school years: 2001-2002 through 2004-2005. SALT data, drawn from every public school in Rhode Island each year, are usually collected in the early to mid spring, similar to the timing for our survey. Figure 9 displays the results across the four years. For the first three years, the eighth graders in our treatment schools showed similar levels of alcohol use to the rest of the eighth graders in the state, starting from an almost identical level (approximately 29%), moving to slightly higher levels, and then to slightly lower levels. In the fourth year, 2004-2005, when the students who had received the programs for the past three years were in eighth grade, there is a clear downward trend not shared by the rest of the schools. The reduction in rate of use between eighth graders in 2002-2003, when our comparison group was surveyed, and 2004-2005, when our treatment group was surveyed, is 43%. This is quite similar to the 45% difference we found in our own survey (see Table 16). We conclude that the difference we found with our own survey is not a result of a statewide trend toward lower use over the course of the study, strengthening our belief that the effectiveness of the programs accounts for the difference.

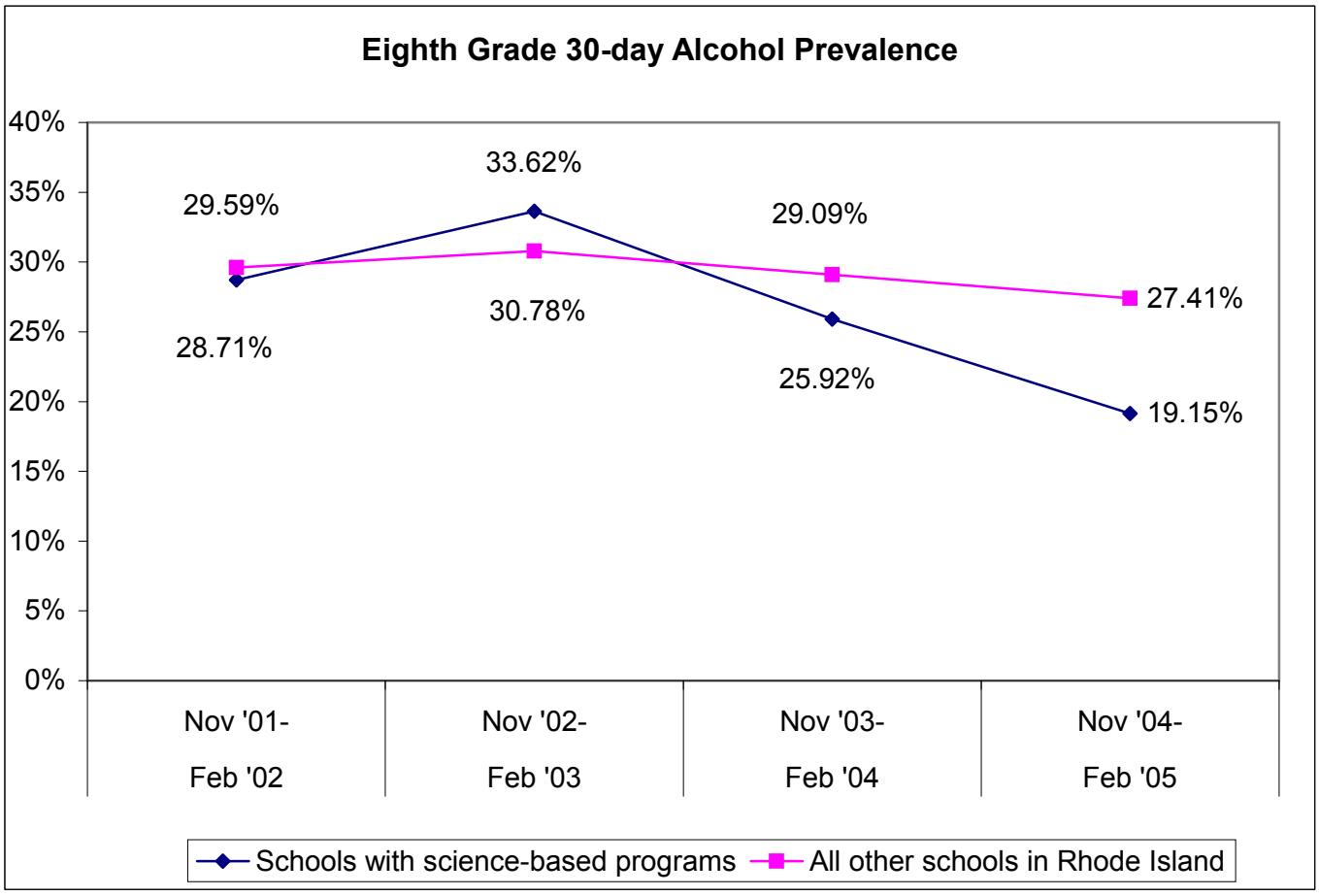

Figure 9. Comparison of Science-based treatment groups with SALT survey results over 4 years

Contrast of Sixth Grade Pre-test to Eighth Grade Post-test for the Treatment Group

For measures of outcome objectives (i.e. 30-day prevalence of use and problem drinking; initiation of use cannot be used in this type of comparison), we examined the amount of the change in use from sixth grade (initial pre-test) to eighth grade (final post-test) for the youth who we could track. We used logistic regressions to determine whether the type of program that the youth received could predict their use or non-use in eighth grade, controlling for their use levels in sixth grade. It is important to note that because we calculated separate significance tests for each dependent variable we increased the risk of family-wise error. Consistent with our report for the comparison of treatment and comparison groups, we have selected 30-day prevalence of alcohol use as the best illustration of program effects. We also selected three demographic variables, gender, eligibility for subsidized lunch (which reflects socioeconomic status), and White non-Hispanic/Latino vs. non-White and/or Hispanic/Latino, as control factors to examine whether the programs had differential effects for demographic sub-groups.

As expected, alcohol use in the past 30 days increased from sixth grade to eighth grade for youth in both the LST and PN samples (see Table 25). Although it appears that the increase in use was not as great for the LST students, we did not find that the type of program was significantly related to use after controlling for initial use.

Table 25. Comparisons of Sixth Grade to Eighth Grade Reports of 30-Day Alcohol Use by the Treatment Group

Program	6th-pre-test	8th post-test	Absolute Change
LST	5.9%	9.4%	3.5%
PN	3.4%	11.8%	8.3%
Combined	4.6%	10.7%	6.1%

Likewise, we did not find that the program had differential effects for the various demographic sub-groups (see Table 26 for race, 27 for S.E.S., and 28 for gender). However, it is interesting to note that substance use for non-whites in LST went down over the three years.

Table 26. Comparisons of Sixth Grade to Eighth Grade Reports of 30-Day Alcohol Use by the Treatment Group, Controlling for Race

Program	Race	6th Pre-test	8th Post-test	Absolute Change
LST	White	3.4%	9.6%	6.2%
	Non-White	11.6%	8.7%	-2.9%
PN	White	2.6%	11.2%	8.6%
	Non-White	7.1%	13.9%	6.8%

Table 27. Comparisons of Sixth Grade to Eighth Grade Reports of 30-Day Alcohol Use by the Treatment Group, Controlling for S.E.S.

Program	S.E.S.	6th Pre-test	8th Post-test	Absolute change
LST	Full-pay Lunch	4.5%	8.4%	3.9%
	Subsidized Lunch	8.9%	12.1%	3.2%
PN	Full-pay Lunch	2.9%	10.5%	7.6%
	Subsidized Lunch	5.8%	17.3%	11.5%

Although it appears that males receiving the LST treatment were less likely to increase their use of alcohol over time, there were no significant differential effects by gender. For one dependent variable, program did predict substance use. The type of program predicted 30-day prevalence of marijuana use, even after controlling for initial use. Consistent with the pattern of use across all substances we included in our questionnaire, the PN youth started out in sixth grade with lower levels of use but rose to higher levels of use following the three years of the program.

Table 28. Comparisons of Sixth Grade to Eighth Grade Reports of 30-Day Alcohol Use by the Treatment Group, Controlling for S.E.S.

Program	Gender	6th Pre-test	8th Post-test	Absolute change
LST	Male	7.2%	8.2%	1.0%
	Female	4.6%	9.9%	5.3%
PN	Male	3.1%	11.2%	8.1%
	Female	3.5%	12.0%	8.5%

Graphic presentation of alcohol 30-day prevalence over three years

We examined the pattern of change in alcohol use over the three years of the project for our treatment group. We included the initial pre-test (time 1) and the three post-tests (times 2, 4, and 6). Figures 10 and 11 present these findings. In Figure 10, the treatment cohort is separated into four groups: LST males, LST females, PN males, and PN females. For all four of the groups there is a predictable increase in alcohol use across the three post-tests. The only striking observation is that LST males show a large decrease in reported alcohol use between time 1 and time 2. Because of that, they ultimately have a lower use level than the other groups at the end of the third year.

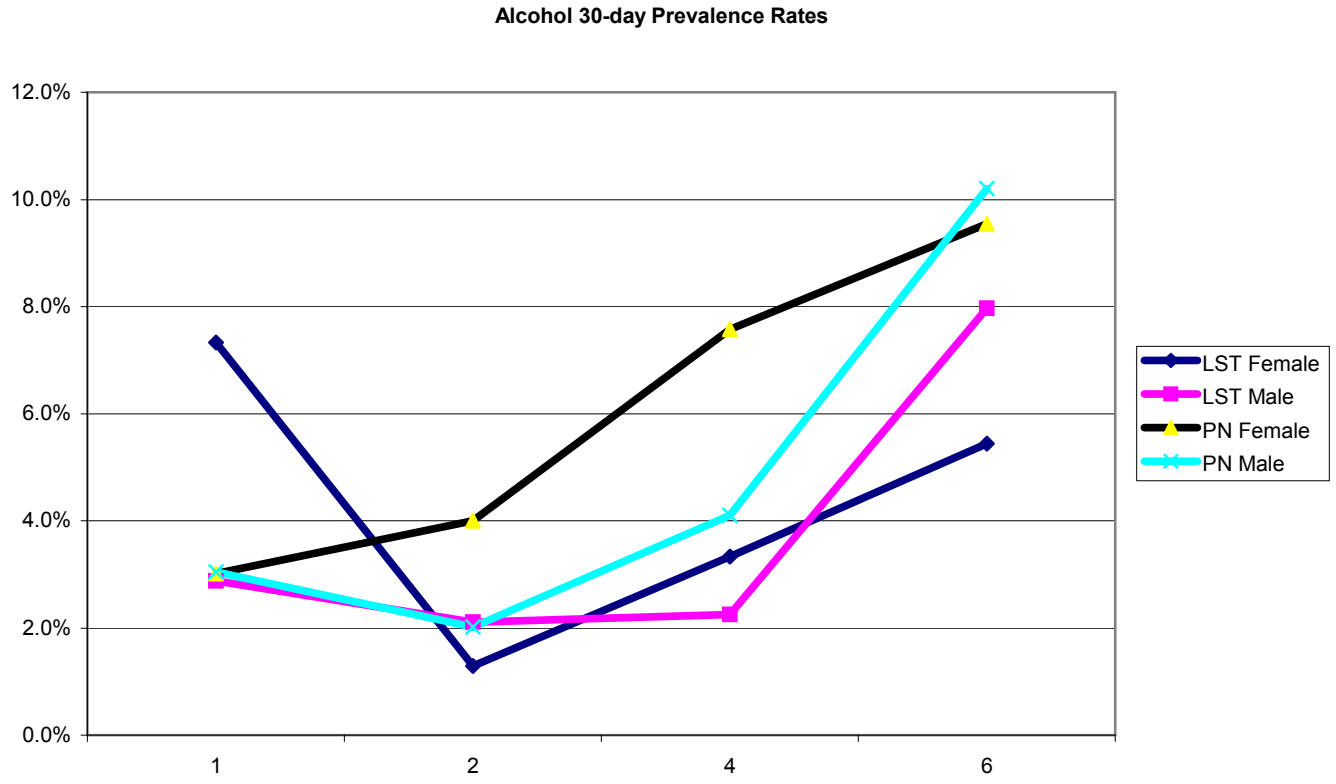

Figure 10. 30-day Alcohol Prevalence by Gender

Figure 11 separates the treatment cohort into four groups distinguishing by race: LST white, LST non-white, PN white, and PN non-white. White students show the predictable pattern of increase across the three post-tests. Non-whites, however, look very different. Those in the LST group show a sharp decrease in use from time 1 to time 2, which leaves them with the lowest use level at the end of year three. Non-whites exposed to Project Northland, on the other hand, show a dramatic increase in use between the end of 7th grade and the end of 8th grade, with 14% reporting use at that point.

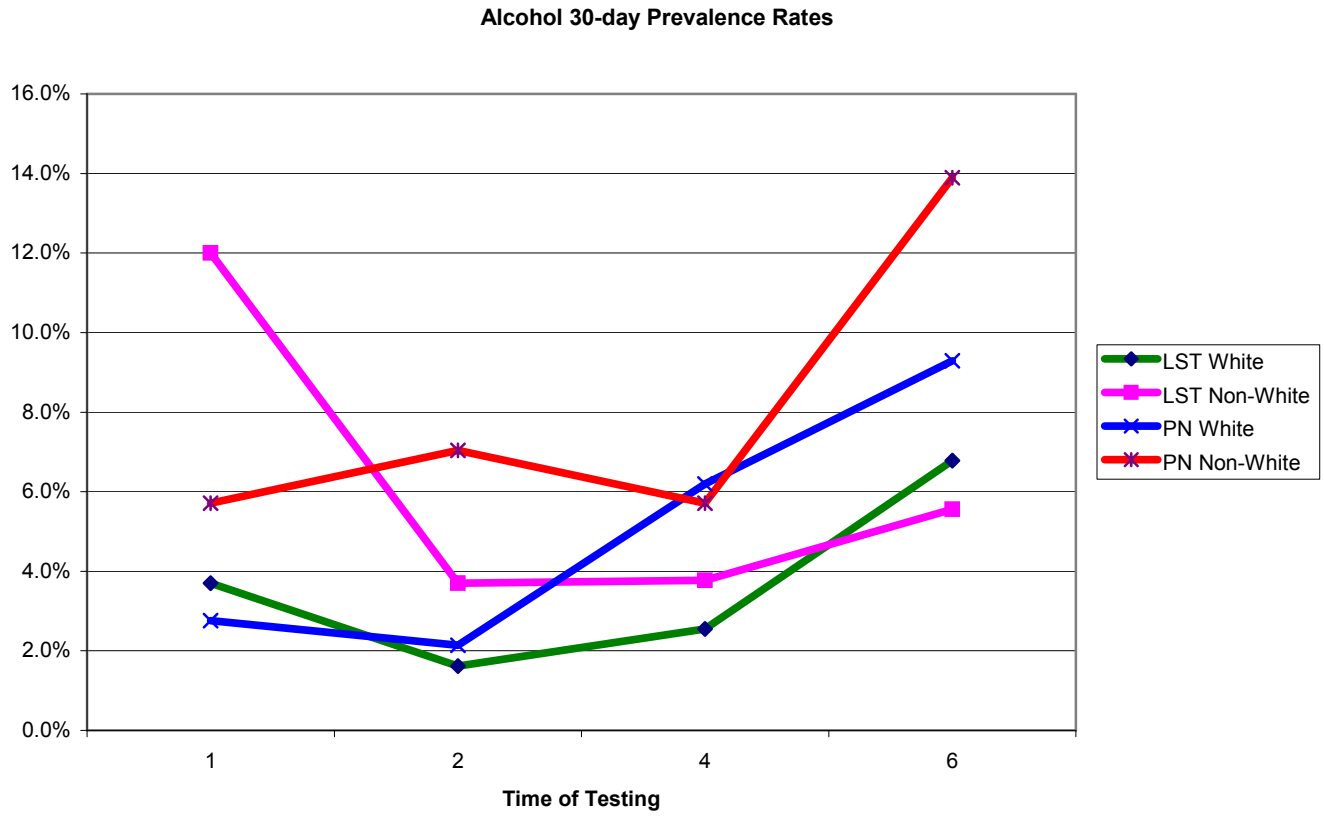

Figure 11. 30-day Alcohol Prevalence by Race

CONCLUSIONS

Did the programs reach the intended target population?

Both school-based programs reached relatively large numbers of students, with 669 in the 8th grade Project Northland treatment group and 657 in the 8th grade Life Skills Training treatment group, for a total of 1,326 students having received one of the prevention curricula at the time we conducted outcome analyses. In the matched sample for whom we have data tracked across all three years of the interventions, there were 536 in Project Northland and 485 in Life Skills Training, for a total of 1,021. Clearly we have enough statistical power to detect even modest effects for both of the classroom curricula.

For our comparison of treated 8th graders to comparable untreated eighth graders from the same schools, we checked the demographic similarity of these two groups and found that they were generally similar on most demographic variables we examined (gender, age, race/ethnicity, eligibility for subsidized lunch (an indication of socioeconomic status), family composition, and average grades). For example, both groups were approximately 50% female, and ranged from 67.5% to 83.6% white, 55.3% to 79.7% ineligible for

subsidized lunch, 71.5% to 79.7% in two-parent families, and 57.1% to 63.5% with grades mostly B or better. Looking at the two programs separately, there was a noticeable difference between treatment and comparison groups in the LST schools on race/ethnicity (higher percent white for the comparison group) and full-pay lunch (higher percent full-pay for the comparison group). One school in our sample was strikingly different from the others (lower percent white, and higher eligibility for subsidized lunch) and this led to an overall difference between the Life Skills Training sample (which included this school) and the Project Northland sample. The non-random way in which schools chose the curricula make any comparisons of the two classroom curricula suspect, particularly in the light of the noted demographic differences between the samples. For example, 75.8% of the Project Northland treatment group paid full price for their lunches, whereas only 55.3% of the Life Skills Training treatment group did so.

For the analyses in which we looked at changes from our initial 6th grade pre-test (Time 1) to our final 8th grade post-test (Time 6), we checked on the attrition in our matched sample. The participants for whom we could link Time 1 to Time 6 were demographically different from the students we assessed at Time 1 but were unable to match at Time 6. Consistent with the literature, attrition was non-random and the students lost from the study were lower in Percent white, full-pay lunch, two-parent family, and grades of B or better. This limits the generalizability of the findings for these analyses. Because of this, our 8th grade comparisons are more representative of the overall school populations.

For the Iowa Strengthening Families Program, we had 98 youth and 106 parents for whom we could analyze results matching pre-tests to post-tests for the first 7-session unit of the treatment. This represents only 7.4% of the 1,326 8th graders in our treatment sample for the classroom curricula. We found that the students in the ISFP program were more likely to be white and less likely to be in two-parent families than the youth treatment cohort as a whole. The relatively small sample in this program reduced our ability to detect statistically significant effects; furthermore, the subgroup of youth who participated was not entirely representative of the larger treatment cohort.

Were the programs delivered with fidelity?

All of the reports by our educators on their success in following the curriculum plans provided by program developers indicated relatively good fidelity. The highest fidelity was for the ISFP program (94.9%), followed by PN (88.4%). With the most sessions, LST was somewhat lower in fidelity at 80.1%, still respectable.

What were the properties of our measures of program outcomes?

We employed a number of measures in order to capture the effects of the programs on more proximal outcomes (intermediate objectives) likely to be directly affected by the programs, as well as the effects on the RFP-specified outcome objectives (30-day prevalence of drug use, initiation of drug use, and problem drinking). Some of the measures of intermediate effects were administered to all of our participants ("shared" measures) while others (designated "non-shared") were chosen to be specific to one of the programs (PN, or LST). For the drug use outcomes we focused primarily on alcohol because it is the most prevalent for this age group and is often viewed as a "gateway drug." In measuring intermediate effects for the ISFP program we chose five constructs and had both parents and youth report on them with slightly different items. The scales were drawn from a number of well-known sources and were uniformly acceptable in internal consistency reliability (Cronbach's Alpha) with our sample. In several cases the distributions of responses were non-normal and required transformations for our statistical analyses.

How did the programs do in the first year?

Effects on Year One objectives for changes on program-specific intermediate outcomes were disappointing for all three programs. One objective out of 14 was achieved for the classroom curricula: social skills (as reported by the youth) increased 19.5% from pre- to post-test for the LST group. None of the five objectives for ISFP was achieved. One likely problem is that the objectives were set too optimistically. Major research studies used in developing model programs are likely to produce much stronger effects than implementations in "real-world" contexts such as ours in this project. However, some of the trends were in the wrong direction (e.g. stress management, perceived peer use, and youth reports of parental expectations of non-use). In the light of the more promising results we will report from the 8th grade comparison group design, it may be valuable to reflect on the limited utility of single-year pre-to post-test comparisons as a means of demonstrating program effects. Adolescents are likely to be headed in the negative direction on many of the risk and protective factors most likely to be measured in substance abuse prevention evaluation, and even relatively powerful programs may not reverse these normal developmental trends – just slow them down.

Did the programs achieve intermediate objectives by eighth grade?

When we compared our 8th grade treatment group to untreated 8th graders from the same schools, we found that there was a highly significant difference for the seven "shared" outcome measures, indicating significant benefit from the programs. Six of the seven scales showed positive effects, with the largest differences for Favorable Attitudes Toward Drug Use and Drug Use Intentions (both lower for our treatment group). Only Family Attachment did not show a significant effect.

All four intermediate objectives specific to Project Northland showed modest but significant effects in the right direction. This included effects on parents (youth-perceived quality of parent communication and rule enforcement for ATOD use). For Life Skills Training, three of five intermediate outcome measures showed modest positive effects (higher drug refusal skills, reduced pro-drug attitudes, and lower perceived peer norms). There were no significant effects for the broader social functioning measures (social skills and stress management).

We also examined the changes from Time 1 to Time 6 for two intermediate outcomes we thought might show positive effects over time: Family Attachment and Parental Attitudes Toward Drug Use. We found that after some initial effects of the programs in the first year on parental disapproval of use, natural developmental changes appeared to dominate and perceived disapproval declined steadily. There were no program effects on attachment, which also declined over time, as we would expect for adolescents.

What about ISFP effects on intermediate outcomes? Parents indicated significant improvement over time on all five outcomes, but their offspring disagreed on four of the five. Only one intermediate outcome showed significant positive change for both parents and youth in ISFP: there was a significant increase in "Limit Setting and Monitoring." This is worth celebrating, as it is an important protective factor.

Did the programs achieve effects on substance use outcomes?

This question represents the "bottom line" for this project. We focused primarily on comparisons between treated and untreated eight graders to address it. For 30-day prevalence of alcohol use, probably the most widely chosen indicator for studies with this age group, both programs produced substantial effects (45% lower alcohol use than for the comparison group) that were highly significant and did not differ between the two classroom curricula. We also used SALT data to confirm this finding,

demonstrating that eighth graders in our intervention schools did show increasing reductions in alcohol use over the past three years while the rest of the schools in the state experienced a much more modest decline. For a second important outcome measure, initiation of alcohol use during the three years of the programs, there was a significant effect when both programs were combined but this was due to the substantial effect of Project Northland (42% lower initiation than the comparison group) and did not show up for the Life Skills Training intervention. We also looked at whether adding the Iowa Strengthening Families Program to the classroom curricula increased the effects on these outcomes, and did not find a significant added effect. However, there are important qualifications for this conclusion, including the small sample size and the weak self-report measure we had of participation in ISFP for these analyses.

Did the two youth-oriented programs affect demographic groups differently?

To check on how the programs did with youth from differing ethnic and economic backgrounds, as well as how the programs might have affected boys and girls differently, we conducted some analyses that examined effects on our two primary outcome measures, 30-day prevalence of alcohol use and initiation of alcohol use, for these subgroups. There were some interesting differences in program effects, and these also varied by outcome measure. To summarize briefly: (1) for 30-day prevalence, LST had greater positive effects than PN for white and full-pay (i.e. higher S.E.S.) students, while PN had greater positive effects on male students than LST did; (2) for initiation of use, PN had significantly more positive effects than LST for non-white students, lower S.E.S. students, and both boys and girls.

What final conclusions do we draw about program effectiveness?

It might help to think of "initiation" as referring to <u>any</u> experimentation with alcohol, while "30-day-prevalence" refers to more regular use over time. If reducing 30-day prevalence is the goal, <u>both</u> programs did very well and LST was especially effective for white and higher S.E.S. students; if the goal is decreasing initiation of use PN is a more promising choice, especially for non-white and lower S.E.S. students.